

Treating Substance Use Disorder in Older Adults

UPDATED 2020

TREATMENT IMPROVEMENT PROTOCOL

TIP 26

SAMHSA

Substance Abuse and Mental Health
Services Administration

Chapter 5—Treating Drug Use and Prescription Medication Misuse in Older Adults

KEY MESSAGES

- Illicit drug use and prescription medication misuse do occur in older adults, but they are treatable.
- Regular screening and assessment can help you learn whether an older client is struggling with drug use or prescription medication misuse.
- Education and brief interventions are often enough to help older adults prevent, reduce, or stop drug use and prescription medication misuse. Most older clients who use illicit drugs or misuse prescription medication do not need care from programs or providers that specialize in substance use disorder (SUD) treatment.
- Age-specific and age-sensitive treatments are useful in reducing drug use and prescription medication misuse and related health risks. These treatments are designed to meet the special physical, cognitive, and social needs of older individuals. For many older adults, these adaptations can make all the difference in helping them start, stay in, and benefit from treatment.

Chapter 5 of this Treatment Improvement Protocol (TIP) will benefit healthcare, behavioral health service, and social service providers who work with older adults (e.g., physicians, nurse practitioners [NPs], physician assistants, nurses, social workers, psychologists, psychiatrists, mental health counselors, drug and alcohol counselors, peer recovery support specialists). It addresses drug use, prescription medication misuse, and SUDs other than alcohol use disorder among older adults.

Prescription medications are some of the most commonly misused substances in this population,⁸⁰³ and rates of substance misuse in general are increasing. These increases result, in part, from the

size of the aging baby boomer generation (those born from 1946 to 1964) and the fact that baby boomers are living longer and have higher rates of lifetime substance misuse, including SUDs, than past generations.

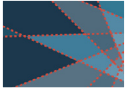
Many older adults who misuse substances do not need specialized SUD treatment. Prevention strategies and brief interventions are often enough. Even so, research shows that older adults do benefit from addiction treatment.^{804,805,806} In fact, older adults in addiction treatment programs are more likely than younger adults to complete treatment, and older adults have nearly as good or better outcomes.^{807,808} Thus, as the older population in the United States grows, the need for a full range of treatment approaches that meet the unique requirements of older adults will continue to increase.

Organization of Chapter 5 of This TIP

This chapter of TIP 26 addresses rates of drug use and prescription medication misuse, including drug use disorders, among older adults as well as treatment and recovery management approaches that meet older adults' specific needs.

The first section of Chapter 5 describes illicit drug use and prescription medication misuse, including drug use disorders, among older adults. Definitions and facts are discussed as well as the physical, mental, social, and economic effects of drug use disorders.

The second section describes how to identify, screen, and assess for drug use disorders in older adults. The parts of screening, brief intervention, and referral to treatment (SBIRT) are discussed, along with specific tips for screening older adults.



The third section describes the continuum of care for older adults with drug use disorders, which ranges from brief interventions for prescription medication misuse to inpatient detoxification and rehabilitation for older adults with drug use disorders.

The fourth section discusses specific treatment approaches for older adults with drug use disorders. These approaches include acute care, overdose treatment, medically supervised withdrawal, medication maintenance therapy, psychosocial approaches, age-specific treatment options, referral management, and care coordination.

The fifth section provides an overview of recovery management strategies for older

adults with drug use disorders. It covers topics such as family member involvement in treatment and linking older adults to evidence-supported, community-based recovery support groups such as Narcotics Anonymous (NA) and Alcoholics Anonymous (AA).

The sixth section provides clinical scenarios. This section uses clinical case material to show how to apply approaches and strategies discussed in Chapter 5 to older clients.

The seventh section identifies targeted resources to support your practice. A more detailed resource guide is in Chapter 9 of this TIP.

For definitions of key terms you will see throughout Chapter 5, refer to Exhibit 5.1.

EXHIBIT 5.1. Key Terms

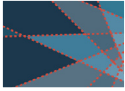
- **Addiction*:** The most severe form of SUD, associated with compulsive or uncontrolled use of one or more substances. Addiction is a chronic brain disease that has the potential for both recurrence (relapse) and recovery.
- **Age-sensitive:** Adaptations to existing treatment approaches that accommodate older adults' unique needs (e.g., a large-print handout on the signs of substance misuse).
- **Age-specific:** Treatment approaches and practices specifically developed for older adults (e.g., an older adult specialty group in a mixed-age SUD treatment program).
- **Caregivers:** Informal caregivers provide unpaid care. They assist others with activities of daily living (ADLs), including health and medical tasks. Informal caregivers may be spouses, partners, family members, friends, neighbors, or others who have a significant personal relationship with the person who needs care. Formal caregivers are paid providers who offer care in one's home or in a facility.⁸⁰⁹ Most older adults do not need caregivers and are as able to address their own needs as younger adults, whether or not substance misuse is a factor in their lives.
- **Diversions:** A medical and legal term describing the illegal sharing of a legally prescribed, controlled medication (e.g., an opioid) with another individual.
- **Drug–drug interaction:** The interaction of one substance (e.g., alcohol, medication, an illicit drug) with another substance. Drug–drug interactions may change the effectiveness of medications, introduce or alter the intensity of side effects, and increase a substance's toxicity or the concentration of that substance in a person's blood. Potentially serious interactions can also occur with certain foods, beverages, and dietary supplements.⁸¹⁰
- **Drug use:** The full range of severity of illicit drug use, from a single instance of use to meeting criteria for a drug use disorder.
- **Illicit substances:** Illicit substances include cocaine, heroin, hallucinogens, inhalants, methamphetamine, and prescription medications that are taken other than as prescribed (e.g., pain relievers, tranquilizers, stimulants, sedatives).

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- **Mutual-help groups:** Groups of people who work together on obtaining and maintaining recovery. Unlike peer support (e.g., the use of recovery coaches or peer recovery support specialists), mutual-help groups consist entirely of people who volunteer their time and typically have no official connection to treatment programs. Most are self-supporting. Although 12-Step groups such as AA and NA are the most widespread and well researched type of mutual-help groups, other groups may be available in some areas. They range from groups affiliated with a religion or church (e.g., Celebrate Recovery, Millati Islami) to purely secular groups (e.g., SMART [Self-Management and Recovery Training] Recovery, Women for Sobriety).
- **Peer support:** The use of peer recovery support specialists (e.g., someone in recovery who has lived experience in addiction plus skills learned in formal training) to provide nonclinical (i.e., not requiring training in diagnosis or treatment) recovery support services to individuals in recovery from addiction and to their families.
- **Prescription medication misuse:** The full range of severity of problematic use of prescription medication (meaning using a medication to feel good, using more than prescribed or in a way not prescribed, or using medication prescribed to someone else), from mild misuse to meeting criteria for an SUD.
- **Psychoactive substances:** Substances that can alter mental processes (e.g., cognition or affect; in other words, the way one thinks or feels). Also called psychotropic drugs, such substances will not necessarily produce dependence, but they have the potential for misuse or abuse.⁸¹¹
- **Recovery*:** A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential. Even individuals with severe and chronic SUDs can, with help, overcome them and regain health and social function. This is called remission. When those positive changes and values become part of a voluntarily adopted lifestyle, that is called being in recovery. Although abstinence from all substance misuse is a cardinal feature of a recovery lifestyle, it is not the only healthy, pro-social feature.
- **Relapse*:** A return to substance use after a significant period of abstinence.
- **Remission:** A medical term meaning a disappearance of signs and symptoms of the disease or disorder. The fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) defines remission as present in people who previously met SUD criteria but no longer meet any SUD criteria (with the possible exception of craving).⁸¹² Remission is an essential element of recovery.
- **Substance misuse*:** The use of any substance in a manner, situation, amount, or frequency that can cause harm to users or to those around them. For some substances or individuals, any use would constitute misuse (e.g., underage drinking, injection drug use).
- **Substance use disorder*:** A medical illness caused by repeated misuse of a substance or substances. According to DSM-5,⁸¹³ SUDs are characterized by clinically significant impairments in health and social function, and by impaired control over substance use. They are diagnosed through assessing cognitive, behavioral, and psychological symptoms. SUDs range from mild to severe and from temporary to chronic. They typically develop gradually over time with repeated misuse, leading to changes in brain circuits governing incentive salience (the ability of substance-associated cues to trigger substance seeking), reward, stress, and executive functions like decision making and self-control. Multiple factors influence whether and how rapidly a person will develop an SUD. These factors include the substance itself; the genetic vulnerability of the user; and the amount, frequency, and duration of the misuse. Note: A severe SUD is commonly called an addiction. A mild SUD is generally equivalent to what previous editions of DSM called substance abuse; a moderate or severe SUD is generally equivalent to what was formerly called substance dependence.

* The definitions of all terms marked with an asterisk correspond closely to those given in *Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health*. This resource provides a great deal of useful information about substance misuse and its impact on U.S. public health. The report is available online (<https://addiction.surgeongeneral.gov/sites/default/files/surgeon-generals-report.pdf>).



Drug Use and Prescription Medication Misuse Among Older Adults

Drug use and prescription medication misuse are growing problems among older adults. In the next decade, approximately 20 percent of the U.S. population will be over age 65.⁸¹⁴ As the large baby boomer population ages up, drug use and prescription medication misuse will likely increase.

This group has higher rates of illicit drug use than past generations,^{815,816} and their misuse of pain medication and other prescription medication is significant.

Taking opioids for pain is one pathway to drug use or prescription medication misuse for older adults. They may start taking opioids for pain and become physically dependent.

Other than alcohol and tobacco, the most commonly misused substances among older adults are psychoactive prescription medications, such as opioids and benzodiazepines (i.e., medications for sleep, pain, and anxiety). Research shows that older adults also use cannabis, cocaine, and heroin. For example, past-year cannabis use by older adults increased from 2006 to 2013 by 57.8 percent for adults ages 50 to 64 and by 250 percent for adults ages 65 and older.⁸¹⁷

Drug use and prescription medication misuse can lead to many negative health outcomes for older adults, such as:

- Increased risk of injury and falls.
- Problems with thinking (also called cognitive impairment).
- Harmful drug–drug interactions.

Prescribed medication is not always misused on purpose. Older adults:

- Can accidentally take more of a prescribed medication than they meant to.
- Can accidentally mix up medications.
- May not know the potential risk of harmful effects of using certain substances (e.g., over-the-counter [OTC] medications, dietary supplements) while taking medication, even when taking it as prescribed.

- Overdose, which can be fatal.
- Suicide.
- Liver and heart disease.
- Sleep problems.

Drug use and prescription medication misuse have negative economic effects. They cost the United States billions of dollars each year, including \$193 billion for illicit substances in 2007⁸¹⁸ (the last year in which those numbers were reported) and \$78.5 billion for prescription opioids in 2013⁸¹⁹ (the last year in which those numbers were reported). Drug use and prescription medication misuse also lead to greater healthcare costs. Older adults already use more healthcare resources than younger adults. As older adults with drug use disorders age, they are at an increased risk of co-occurring medical conditions, which means they will use more healthcare services.^{820,821,822}

Drug use and prescription medication misuse among older adults negatively affect relationships, families, and friends. Many family members, friends, and caregivers recognize but minimize drug use or prescription medication misuse among older adults. Well-meaning family and friends may assume that drug use and prescription medication misuse in older adults cannot be treated, especially if the behavior has been going on for a while. They may feel that the time for treatment has passed or that previous attempts at treatment make trying again pointless.^{823,824} Often, friends and family view the use of certain substances by older adults as one of their “last pleasures” or distractions in life.⁸²⁵

Ageist, incorrect beliefs about drug use and prescription medication misuse among older adults can prevent older adults from getting treatment. Treatment access for older adults is key, as research increasingly shows that SUD treatment for older adults can reduce or stop drug use and prescription medication misuse and improve health/quality of life.^{826,827,828,829,830}

Prescription Medication Misuse

Prescription medication misuse includes:

- Taking larger doses of a medication than prescribed.
- Changing the dose without guidance from the prescriber.

- Taking a medication for reasons other than its intended purpose.
- Taking someone else’s medications.

Older adults are prescribed and use more medication than any other age group. From 2015 to 2016:⁸³¹

- An estimated 87.5 percent of adults ages 65 and older took at least one prescription medication in the past 30 days, versus 67.4 percent of adults ages 45 to 64 and 35.3 percent of those ages 18 to 44.
- Adults ages 65 and older were the largest group of people taking five or more prescription medications in the past 30 days (39.8 percent) compared with adults ages 45 to 64 (19.1 percent) and adults ages 18 to 44 (3.9 percent).

Age-related changes to metabolism and body fat affect the medication dosage that older adults need and increase the risk of older adults feeling negative effects of medication. For example, older adults are very likely to feel memory-related and psychomotor effects of benzodiazepines and opioids. Also, older adults have a higher rate of co-occurring conditions than do younger adults, which means they take more medication and are more likely to experience harmful drug–drug, alcohol–drug, and drug–co-occurring condition interactions.^{832,833}

Providers face challenges when prescribing for older adults in general and need to exercise extra caution. One challenge is that a medication may not have a recommended dosage for older adults, in which case providers should prescribe the minimum dosage needed to achieve a positive outcome. Prescribers also need to think about what formulation of a medication will work best for an older patient and what dosing schedule will be easiest to follow. Yet another common challenge is that older patients may be taking unnecessary medication given their specific clinical conditions. Such medication should be discontinued, consulting with the patient and using tapering as appropriate.^{834,835} Also, some medications are potentially inappropriate for older adults: see the Chapter 6 text box on the American Geriatrics Society Beers Criteria®.

Younger people tend to misuse psychoactive prescription medication for mood effects (i.e., wanting to feel very happy or euphoric), but **older adults tend to develop drug use disorders because they are using drugs or misusing prescription medication to treat their chronic pain, anxiety, depression, and sleep issues.**^{836,837,838}

Opioids

The United States is facing an opioid use and overdose crisis. (See SAMHSA’s TIP 63, *Medications for Opioid Use Disorder*, for more information; <https://store.samhsa.gov/product/TIP-63-Medications-for-Opioid-Use-Disorder-Full-Documents/PEP20-02-01-006>). The years 2006 to 2013 saw an increase in calls to U.S. poison control centers about older adults’ misuse of prescription opioids, including misuse of prescription opioids for self-harm.⁸³⁹

Chronic pain is one of the most common reasons for taking medication. Older adults have the highest rate of chronic pain of any age group,⁸⁴⁰ leading to more clinic visits and increased prescribing of opioid medication. Older adults with opioid use disorder (OUD) and chronic pain may have a hard time accepting that they have OUD.

Benzodiazepines

Benzodiazepines (e.g., lorazepam, alprazolam, clonazepam) are mainly used to treat sleep and anxiety disorders. Benzodiazepines are thought to be safer than barbiturates and nonbarbiturate sedative-hypnotics.⁸⁴¹ **However, the physical dependence potential for benzodiazepines is very high. Long-term use or misuse of benzodiazepines in older adults has many risks.** Results from more than 68 clinical trials show that benzodiazepines, no matter how long they are used (either short-, intermediate-, or long-acting) can lead to cognitive impairment. The greater the dose, the greater the impairment.⁸⁴²



Many older adults experience adverse drug reactions because they are managing numerous prescribed medications (sometimes from multiple prescribing physicians). Adverse drug reactions are not necessarily the result of intentional or accidental misuse; rather, they result from complying with a dangerous regimen of drugs.

Multiple Medications

The aging process causes changes to the body that increase the chances of older adults feeling negative effects of medication. For example, older adults have decreased ability to metabolize drugs. **Older adults often take more than one medication.⁸⁴³ Negative effects are more likely to occur when older adults take many OTC or prescription medications.⁸⁴⁴** Taking more than one medication that affects the central nervous system (CNS) increases the risk of:⁸⁴⁵

- Problems with daily functioning.
- Cognitive impairment.
- Falls.
- Death.

Coprescribing of opioid and benzodiazepine medications is a concern. The risk of death increases with the dose of benzodiazepine prescribed.⁸⁴⁶ In 2016, the Food and Drug Administration (FDA) issued a Drug Safety Communication warning about serious risks, including respiratory depression and death, from combining opioids with benzodiazepines or other CNS depressants (e.g., **alcohol**), and requiring boxed warnings for prescription opioids and benzodiazepines. FDA also cautioned that healthcare professionals “should limit prescribing opioid pain medicines with benzodiazepines or other CNS depressants only to patients for whom alternative treatment options are inadequate. If these medicines are prescribed together, limit the dosages and duration of each drug to the minimum possible while achieving the desired clinical effect.” FDA further advised healthcare professionals to screen these patients for SUDs, plus listed other precautions.⁸⁴⁷ Note that even greater caution should be used with older patients because of their higher risk of experiencing negative effects from medication.

FDA in 2017 advised against withholding buprenorphine or methadone treatment for OUD from patients taking benzodiazepines or other CNS depressants, but recommended careful medication management of these patients. Although combining these OUD medications with CNS depressants increases the risk of serious side effects, FDA noted that this risk can be outweighed by the risk and harm of untreated OUD.⁸⁴⁸ For strategies on caring for these patients, see the FDA Drug Safety Communication at www.fda.gov/drugs/drug-safety-and-availability/fda-drug-safety-communication-fda-urges-caution-about-withholding-opioid-addiction-medications and the section “Concurrent Substance Use Disorders (SUDs) Involving Benzodiazepines or Alcohol” in SAMHSA’s TIP 63 (<https://store.samhsa.gov/product/TIP-63-Medications-for-Opioid-Use-Disorder-Full-Document/PEP20-02-01-006>). Again, keep in mind the need for using extra caution with older patients.

Illicit Substances

Illicit substances include cocaine, heroin, hallucinogens, inhalants, methamphetamine, and prescription medications that are taken other than as prescribed (e.g., pain relievers, tranquilizers, stimulants, sedatives). Because federal law bans the recreational and medical use of cannabis, this publication considers it an illicit substance (although in some states, medical use of cannabis is legal and in others, both recreational and medical use are legal).

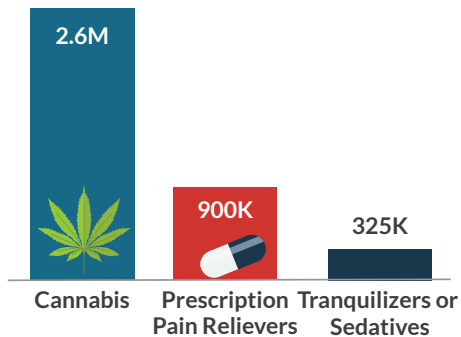
In 2019, 3.7 million adults ages 65 and older had used illicit substances in the past year.⁸⁴⁹ Of these drugs, older adults most commonly used:⁸⁵⁰

- Cannabis: 2.6 million adults.
- Prescription pain relievers: 900,000 adults.
- Tranquilizers or sedatives: 325,000 adults.

From 2000 to 2012, SUD treatment admissions for illicit substance use increased for adults ages 55 or older.⁸⁵¹

Rates of cannabis use among older adults are likely to continue rising. This is a major concern as baby boomers, who tend to be more accepting of cannabis use than previous generations, enter

3.7 MILLION ADULTS ages 65 and older used **ILLICIT SUBSTANCES** in 2019.



the later stages of life. From 2000 to 2019, the percentage of adults ages 50 to 64 who had ever used cannabis increased from approximately 24 percent to around 54 percent.^{852,853}

The effects of using cannabis while also taking specific prescription medications are not known. However, **cannabis use is related to an increased risk of injury and short-term memory problems.** Cannabis affects central and peripheral nervous system processes in ways such as:^{854,855,856,857}

- Increasing symptoms of anxiety and depression.
- Increasing problems with cognition and learning.
- Worsening motor coordination (i.e., the ability to use and control muscle movements).

Moreover, the increasing potency of cannabis in recent decades may make cannabis use riskier.⁸⁵⁸

Screening and Assessment

If you think a client might be using drugs or misusing prescription medication, screening measures will help you identify and address this behavior.⁸⁵⁹ Screening older adults for drug use and prescription medication misuse and providing education about health risks related to interactions between prescribed medication, alcohol, and illicit substances are prevention strategies you can use in many different settings.

Screen and assess older adults for substance use and co-occurring medical and mental disorders (e.g., cognitive impairment) that can mask SUDs or appear similar to SUDs.

CO-OCCURRING CONDITIONS AMONG OLDER ADULTS

Older adults with SUDs have high rates of mental disorders and co-occurring health conditions. In 2019, an estimated 36.8 percent of adults older than age 50 with SUDs also had mental disorders.⁸⁶⁰ Co-occurring mental disorders and SUDs among older adults are probably underdiagnosed, so the rates of co-occurring disorders (CODs) may actually be higher.⁸⁶¹

Compared with older adults who have only an SUD or a mental disorder, those with both are at risk for:^{862,863}

- Higher rates of inpatient and outpatient behavioral healthcare service use.
- Thoughts of suicide and of death in general.
- Certain physical conditions related to substance misuse (e.g., heart disease, organ damage, some cancers).

Given high rates of CODs in older adults with SUDs, you should use holistic, detailed approaches to screening, assessment, and treatment.

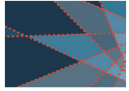
Screening Strategies

To successfully make routine screening for drug use disorders a part of your clinical practice with older adults, **use simple, consistent approaches that can be added to screening practices you already have in place.** Screening questions can be asked verbally, on paper, or electronically. Make sure print is large enough for older adults to read easily. Ask about drug use:⁸⁶⁴

- In a straightforward and nonjudgmental manner.
- While asking about other health behaviors (e.g., exercise, weight, smoking, alcohol use).
- While keeping the focus on helping clients improve their overall health, functioning, independence, and quality of life.

Screen adults ages 60 and older:

- Yearly, as part of the annual checkup in both healthcare and behavioral health service settings.
- When changes in physical or mental health status occur (e.g., falls, memory issues).



- During major life events or changes (e.g., retirement, moving, loss of a significant person).

The consensus panel recommends screening all adults ages 60 and older yearly and when life changes occur (e.g., retirement, loss of a partner or spouse, changes in health).

Several measures can help you screen for substance misuse, but few are validated (tested and approved for use) with older adults.⁸⁶⁵ (See Chapter 3 of this TIP for an indepth discussion of substance use screening tools that can be used with older adults.)

One option is to use screening questions developed for the general adult population. For example, open your conversation with older clients by asking, “Have you taken a prescription medication differently than prescribed by your healthcare provider?” You can also use a single-question screener for drug use, such as, “How many times in the past year have you used an illegal drug or taken a prescription medication for nonmedical reasons?”⁸⁶⁶ If the client says “yes” to the first question or answers the second question with one or more, begin more indepth screening.

Indeath screening includes asking clients about:

- Use of prescription and OTC medications.
- Use of other substances (e.g., alcohol, cannabis, tobacco).
- Amount/frequency of past-month substance use.
- Effects of using substances.
- Concerns about their substance use as well as concerns of family members or friends.

RESOURCE ALERT: NATIONAL INSTITUTE ON DRUG ABUSE-MODIFIED ALCOHOL, SMOKING, AND SUBSTANCE INVOLVEMENT SCREENING TEST

This screening tool (www.drugabuse.gov/sites/default/files/pdf/nmassist.pdf) offers a helpful way to organize your questions about types of substances used, lifetime and recent amount and frequency of substances used, and substance use concerns.

SCREENING FOR USE OF MULTIPLE MEDICATIONS: A BROWN BAG MEDICINE REVIEW

Older adults often take a number of prescribed medications as well as OTC medications and dietary supplements. As part of an annual physical, or given signs that the older client is misusing medications (e.g., benzodiazepines, opioids), urge the client (or a family member, with consent) to bring in all prescribed and OTC medications and dietary supplements in a bag so that you and the client can review them together. This is known as a “brown bag medicine review.” This is a chance to discuss the health risks of taking multiple medications, of drug–drug interactions, and of misuse.^{867,868} **Brown bag medicine reviews can improve client reporting of medication use and improve provider–client discussions about medication use.**⁸⁶⁹

When using verbal, electronic, or printed screeners:

- Be empathetic and nonconfrontational.
- Make the screening questions easy to understand.
- Speak clearly and repeat instructions or questions as needed, especially if the client has cognitive impairment or problems with vision or hearing. Make sure the client can hear and understand you.
- Use large type for printed questions and screen reader–friendly adaptations for computer screening.
- Ask questions about the client’s illicit substance use or prescription medication misuse as a part of assessing overall health status.
- Assess and reassess if the client is having problems using a computer, tablet, or writing on a printed form. If needed, offer a verbal interview in which you read the screening questions.

Assessment and Diagnosis of Drug Use Disorders

Screening is the first step in performing an indepth assessment of substance misuse. Some signs of drug use disorders in older adults may be mistaken for symptoms of co-occurring

LINKING SCREENING QUESTIONS ABOUT SUBSTANCE USE TO HEALTH STATUS

You can help older adults understand the reason for your asking substance use questions by giving them information about age-related changes in metabolism and how specific medications, such as sedatives and antianxiety medications, can negatively interact with alcohol. You can also help older adults understand the relationship between substance use and health outcomes by discussing their substance use and other health problems, such as falls, high blood pressure, and depression.

medical or mental disorders. Using DSM-5 diagnostic criteria alone may underdiagnose older adults who have drug use-related and prescription medication misuse-related health and functioning problems. This can keep clients from getting needed treatment.

A full assessment should include questions about a client's:

- History of substance use (including alcohol and tobacco use).
- Age at which substance misuse issues began.

- Amount and frequency of substance use.
- Current prescription medications, OTC medications, and dietary supplements.
- Co-occurring medical conditions.
- Relationship between substance use and daily functioning.
- Co-occurring mental disorders, particularly depression and anxiety.
- Use of substances to cope with sleep problems, depression, anxiety, stress, or pain.
- Management of daily medication regimens.

Note any signs that clients may be under the influence of substances. Although clients who appear to be so may give incomplete answers, current influence of substances is by itself a clear sign that further assessment and intervention are needed.

DSM-5 Diagnostic Criteria

A formal SUD diagnosis is based on your client meeting 2 out of 11 DSM-5 diagnostic criteria. However, **some of the physical and social factors described in DSM-5 may not apply to older adults** because of age-related changes in tolerance to substances, cognitive functioning, role responsibilities, or social isolation.⁸⁷⁰ **Exhibit 5.2 summarizes the physical, mental, and social aspects of aging you should consider when using these criteria to diagnose SUD in older adults.**

EXHIBIT 5.2. DSM-5 Criteria for SUD and Considerations for Older Adults

DSM-5 CRITERIA FOR SUD⁸⁷¹

CLINICAL CONSIDERATIONS^{872,873,874}

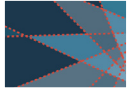
Criterion 1

Older adults may need less of a substance to feel its physical effects. In addition to age-related or co-occurring medical-related decline in cognitive functioning, use of many substances can increase cognitive impairment and the ability to keep track of the amount and frequency of substance use.

Criterion 2

This is the same as in the general adult population. There are no special considerations for older adults.

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DSM-5 CRITERIA FOR SUD	CLINICAL CONSIDERATIONS
Criterion 3	Effects from substance use can occur from using relatively small amounts compared with the general adult population.
Criterion 4	Although older adults may have cravings, they may not recognize substance cravings in the same way as the general adult population (e.g., cognitive decline may increase confusion about physiological cues related to craving).
Criterion 5	Role responsibilities may be different for older adults because of life-stage changes, like retirement. Role responsibilities more common among older adults include caregiving for a spouse with a chronic illness and parenting a custodial grandchild.
Criterion 6	Older adults may not realize their substance use is related to social or interpersonal problems.
Criterion 7	Older adults may participate in fewer activities than younger adults, making it difficult to know whether a reduction in activities is related to substance use. However, social isolation is related to substance use and should be noted and addressed.
Criterion 8	Older adults may not understand that their use is harmful, especially when using substances in smaller amounts. Older adults may not identify certain situations (e.g., using a step stool or taking medications together) as physically dangerous.
Criterion 9	Older adults may not realize their substance use is related to physical (e.g., gastrointestinal distress) or mental problems (e.g., anxiety).
Criterion 10	Because of increased sensitivity to substances with age, older adults may have lowered rather than increased tolerance depending on the substance used.
Criterion 11	Withdrawal symptoms among older adults can be less obvious and more drawn out. Older adults may not develop physical dependence if they started using the substance in late life; if prescribed and correctly using medications like benzodiazepines, they may develop physical dependence.

Biopsychosocial Assessment and Placement

The Level of Care Utilization System for Psychiatric and Addiction Services (LOCUS 20) is an assessment and placement tool that supports adoption of a systematic approach to these important steps in meeting the needs of older adults. The tool can be downloaded for free from www.communitypsychiatry.org/resources/locus.

Continuum of Care

The SUD treatment continuum of care has many **points of intervention where older adults can receive services** (Exhibit 5.3). Treatment for drug use disorders can be delivered in many different settings using behavioral and pharmacological methods.

EXHIBIT 5.3. SUD Treatment Continuum of Care


PREVENTION	EARLY INTERVENTION	TREATMENT	RECOVERY MANAGEMENT
Address individual and environmental risk factors for substance use through science-informed prevention strategies aimed at individuals, families, and communities.	Identify and screen for substance misuse; provide psychoeducation and brief interventions to reduce health risk; refer to treatment as needed.	Provide medication as needed, psychosocial interventions, and supportive services to achieve recovery and maximize functioning. Levels of Care: Outpatient Intensive outpatient/partial hospitalization Residential/inpatient Medically managed intensive inpatient services	Offer comprehensive discharge planning, referral management, continuing care, and linkage to community-based services (e.g., mutual-help groups; medical care; social, legal, educational, and financial services) that support ongoing recovery and improve wellness and quality of life.

Adapted from material in the public domain.⁸⁷⁵

More than 14,500 specialized treatment facilities in the United States provide SUD services, such as:⁸⁷⁶

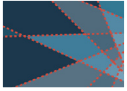
- Counseling.
- Rehabilitation.
- Behavioral therapy.
- Case management.
- Medication therapy.
- Psychoeducation.
- Peer recovery support services.

Early intervention for an older adult's drug use or prescription medication misuse can take place in a healthcare office, a hospital, an emergency department (ED), an outpatient behavioral health clinic, or an older adult-focused social service

agency. Primary care providers (PCPs) are often the entry point for brief interventions and referral to drug use disorder-specific treatment.

Different levels of care include:

- Outpatient individual, group, and family counseling.
- Intensive outpatient care (i.e., daily or weekly individual and group counseling for many weeks/months).
- Residential care (i.e., 24-hour supervision and clinical monitoring).
- Medically managed inpatient care (i.e., treatment services in a medical or mental hospital setting).



When you work with clients to develop a treatment and recovery plan based on their preferences, as well as on the accessibility and appropriateness of the chosen treatment, clients are more likely to follow your recommendations. Unless clients present with active suicidal ideation, withdrawal risks, or an acute health concern (e.g., overdose, significant impairment, delirium, falls), let them choose their preferred treatment method. Offer options and discuss the benefits of each as they apply to each client.

Recovery management, including discharge planning and continuing care, is an important part of the continuum of care. Older adults leaving intensive addiction treatment should:⁸⁷⁷

- Have routine medical care for co-occurring, chronic medical conditions.
- Be linked with older adult-focused, community-based services.
- Be introduced and referred to recovery groups to support their ongoing recovery but also to reduce isolation and loneliness, which are common among older adults. (See Chapter 7 of this TIP for more information about social isolation.)

Treatment Approaches Suited to Older Adults

Many safe and effective interventions exist for older adults who use drugs, misuse prescription medication, or have drug use disorders. You should approach decisions about treatment by considering:

- The drug being used or the prescription medication being misused.
- The level of care needed (e.g., brief intervention, detoxification, maintenance).
- Overdose prevention and treatments.
- Psychosocial approaches adapted to older adults.

This section describes general approaches that work with older adults who misuse prescription medications and use illicit substances. It also describes treatment strategies for specific kinds of substances.

ENDING, CHANGING, OR CONTINUING TREATMENT⁸⁷⁸

Clients' progress in treatment, as gauged by clearly defined, agreed-upon goals, should determine their length of time in treatment. The main criterion for discharge is that clients have met treatment goals. If clients are making progress and that progress is likely to continue, treatment should continue. If clients cannot meet treatment goals or they develop new treatment-related challenges, they should receive recommendations for different types of services or treatments.

SBIRT

Many older adults who use illicit drugs or misuse prescription medication do not need specialized addiction treatment. Education is often enough to help older adults change their behaviors. Older adults often respond well to nonjudgmental, brief education about:

- Medications they are taking.
- Potential drug–drug interactions.
- Negative effects of using medications in ways other than as prescribed.

SBIRT is an indepth approach to screening and brief intervention with older adults who may exhibit at-risk drug use, misuse of prescription medications, or use of illicit substances.⁸⁷⁹

- **Screening** helps you quickly assess the severity of drug use or prescription medication misuse and identifies the right type and intensity of treatment.
- The **brief intervention** focuses on helping older adults increase awareness of their drug use or prescription medication misuse and motivation for changing health risk behaviors.
- **Referral to treatment** secures access to assessment and treatment by providers who specialize in addiction, when needed.⁸⁸⁰ Providers can implement SBIRT in many settings, including behavioral health service programs and healthcare clinics.

Chapter 3 offers in-depth discussion of SBIRT, research on its usefulness, and adaptations for older adults.

Treatment for OUD

Opioid Overdose Treatment

Because of physiological changes, older adults show higher blood concentrations of opioid metabolites. This results in greater substance potency, toxicity, and longer duration of action than in younger adults.^{881,882} These factors may **increase older adults' risk of opioid overdose, which should be treated as a life-threatening emergency.**

Follow recommended guidelines for naloxone administration, and **offer overdose prevention education and emergency naloxone kits to clients, caregivers, and families in case of overdose.**^{883,884}

Medically Supervised Opioid Withdrawal

Older adults are likely to have intense opioid withdrawal symptoms, especially related to chronic pain.

ACUTE CARE: MEDICAL STABILIZATION AND SUPERVISED MEDICAL WITHDRAWAL

Individuals must be medically and mentally stabilized if they:⁸⁸⁵

- Are acutely intoxicated.
- Are having an overdose.
- Are in withdrawal.
- Return to substance use.

Acute inpatient treatment may also be needed for individuals who:

- Are frail.
- Have multiple addictions.
- Have suicidal ideation.

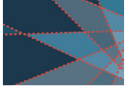
Medically supervised withdrawal in a monitored or managed setting is recommended for older adults who have been taking high doses of a substance (e.g., opioids) or using for a long time.

Inpatient treatment will ensure that individuals are medically monitored for a safe withdrawal process. This is especially important for older adults with co-occurring mental and medical conditions. Monitoring reduces risk of severe negative effects, including death, as older adults have more clinical risks related to withdrawal and medical stabilization.

Medication To Treat OUD

Three FDA-approved medications⁸⁸⁶ can treat OUD in older adults:

- **Buprenorphine. Buprenorphine carries less risk for overdose than methadone.**^{887,888} Buprenorphine's risk of respiratory depression or sedation is low,⁸⁸⁹ and the medication doesn't produce the euphoria caused by heroin or synthetic opioids. Buprenorphine:
 - Is a good option for patients with repeated return to opioid use.
 - Is usually more convenient and cost-effective than methadone, because it can be provided in office-based settings by qualified physicians, NPs, physician assistants, and, until October 1, 2023, qualified clinical nurse specialists, certified registered nurse anesthetists, and certified nurse midwives.
 - Is available as an implant, in sublingual and transmucosal formulations, and as an injection. This makes it a **good option for older adults with mobility or transportation issues, as it reduces the need for frequent visits to the provider.**⁸⁹⁰



- **Methadone.** Methadone can prevent opioid withdrawal symptoms and reduce drug cravings. Methadone is available in almost every state from specially licensed opioid treatment programs. Methadone is a beneficial intervention.⁸⁹¹
- **Naltrexone.** Naltrexone is best for clients who want to stop all opioid use. Research on naltrexone for OUD treatment in older adults is not readily available. It is less useful for individuals needing long-term medication maintenance therapy for SUDs or for those with chronic pain. Naltrexone must not be prescribed to individuals who are currently using opioid medications.

Nonopioid Treatments for Chronic Pain

Older adults may develop OUD because of chronic pain. Given the complexities of managing the care of older clients with chronic pain, a comprehensive treatment approach is recommended.⁸⁹² Chronic pain in older adults is best managed by a multidisciplinary team that includes (when possible) a:

- Geriatrician.
- Rheumatologist.
- Physical medicine and rehabilitation physician.
- Psychiatrist or psychologist.
- Physical therapist.
- Occupational therapist.
- Pharmacist.

Nonpharmacological treatments can successfully treat chronic pain in older adults. These include:⁸⁹⁴

- Meditation.
- Relaxation.
- Cognitive-behavioral therapy (CBT).
- Exercise therapy.
- Physical therapy/occupational rehabilitation.

Exhibit 5.4 shows the general approach to managing chronic pain in older adults.

RESOURCE ALERT: VETERANS AFFAIRS CLINICAL DECISION TOOLS FOR OPIOID USE AND CHRONIC PAIN

The Department of Veterans Affairs/Department of Defense *Clinical Practice Guideline for Opioid Therapy for Chronic Pain* (www.healthquality.va.gov/guidelines/Pain/cot) describes the critical decision points in the management of opioid therapy for chronic pain. It provides clear and comprehensive evidence-based recommendations using current information and practices for practitioners throughout the Department of Defense and Department of Veterans Affairs healthcare systems. It includes special dosing considerations for older adults.

The *Opioid Safety Initiative Toolkit* (www.va.gov/PAINMANAGEMENT/Opioid_Safety_Initiative_OSI.asp), created by the Veterans Health Administration National Pain Management Program, can aid in clinical decisions about starting, continuing, or tapering opioid therapy and other challenges related to safe opioid prescribing. Clinical teams caring for older adult veterans with chronic pain may find this useful.

EXHIBIT 5.4. Chronic Pain Assessment and Treatment Approaches for Older Adults^{895,896}

Assessment. An indepth assessment should review the client's:

- Cognitive and functional status.
- Social support.
- Co-occurring medical and psychiatric conditions and SUDs.
- History of pharmacological and nonpharmacological treatments.
- Current medication and alcohol use.
- ADLs. (See Chapter 3 for more information about assessing these.)
- Goals and hopes for treatment.

Treatment. An indepth approach should include:

- Building a treatment alliance with the older adult by asking about his or her preferences and goals.
- Providing consistent and prompt follow-up to a client's requests and phone calls.
- Providing backup coverage with providers who understand the unique treatment needs of older adults.
- Providing/actively linking the client to physical or occupational therapy and other community-based resources.
- Offering pharmacological (when needed) and other treatments (e.g., CBT, physical therapy, mindfulness).
- Using praise and positive reinforcement when the client meets treatment tasks and goals.
- When necessary, adapting treatment approaches to meet the needs of the older adult.
- Including family and caregivers in treatment planning and recovery/rehabilitation activities (with the older adult's permission).

If you are treating older adults with opioids for chronic pain, do not stop treatment suddenly. This can cause serious withdrawal effects. In addition, the return of pain may lead older adults to misuse or use other prescribed medications, alcohol, OTC medications, and illicit drugs.

The consensus panel recommends that you slowly titrate older adults off of opioids, while at the same time offering them other pharmacological and nonpharmacological treatment options.

Treatment of Drug Use Disorders Other Than OUD

Benzodiazepines

Given the potential risks and harmful effects, medical providers are cautioned against prescribing benzodiazepines to older adults. If a benzodiazepine is needed, prescribe the lowest dose for the shortest amount of time. Harmful effects of benzodiazepines can include:⁸⁹⁷

- Residual sedation.
- Decreased attention.
- Decreased memory and cognitive function.
- Changes in motor coordination.
- Increased risk of falls.
- Drug dependence and withdrawal.
- Increased risk of car accidents.

Although life-threatening benzodiazepine overdoses are rare, the risk is higher in older adults because of age-related declines in medication metabolism. In the event of a benzodiazepine overdose, low doses of a benzodiazepine antagonist are safe for older adults.⁸⁹⁸

Medically supervised withdrawal from benzodiazepines for older adults should include:⁸⁹⁹

- Counseling.
- A stepped withdrawal schedule.
- Client education about benzodiazepine use and withdrawal.



Benzodiazepine withdrawal symptoms can be similar to alcohol withdrawal symptoms. Withdrawal symptoms can include anxiety, sleep disturbances, and life-threatening complications such as seizures. A gradual, tapered approach to medically supervised withdrawal is best.

Because older adults can have withdrawal symptoms even after taking the medication for relatively short periods of time, tapering should be gradual. It should last for a minimum of 4 weeks, although most clients need longer.⁹⁰⁰

One study using a 22-week tapering protocol and education about the tapering process found that 27 percent of clients stopped taking benzodiazepines within 6 months, compared with 5 percent in the control group.⁹⁰¹ A review of 28 studies of older adults tapering off benzodiazepines reported positive outcomes and no serious harmful effects with tapering only (32 percent), tapering and CBT (32 percent), and tapering plus other medication (36 percent).⁹⁰²

Other Sedative-Hypnotics

Medical providers often prescribe sedative-hypnotic medication to older adults for insomnia.

Sedative-hypnotics should not be first-line treatment for insomnia. Some older adults can benefit from benzodiazepines and other sedative-hypnotics as short-term solutions to sleep issues. However, **long-term use of these medications increases the risk of physical dependence. Be very cautious prescribing them to older adults because of the increased risk of:**⁹⁰³

- Memory impairment.
- Falls.
- Fractures.
- Car accidents.

The consensus panel discourages treatment of insomnia with sedative-hypnotics for more than 7 to 10 days. Patients need frequent monitoring and reassessment if treatment continues past 2 to 3 weeks. Intermittent dosing at the lowest possible dose is best. Prescribe no more than a 30-day supply.

SLEEP HYGIENE TO REDUCE INSOMNIA IN OLDER ADULTS

The aging process can cause changes in sleep that lead to increased awakenings during the night. Older clients who practice good sleep hygiene and receive CBT can retrain their bodies and brains for better, more restful sleep. Sleep-related best practices that combine principles of sleep hygiene with CBT include the following:^{904,905,906,907}

- Avoid alcohol and caffeine, especially before bed.
- Take medications in the morning if possible, especially if they are stimulating or cause alertness.
- Don't take daytime naps.
- Follow a regular bedtime.
- Use the bedroom only for sleep and sexual activity; remove TVs, electronics, and items unrelated to sleep.
- Limit exercise to earlier in the day.
- Avoid heavy meals before bedtime.
- Learn relaxation techniques and use them before bed and during night waking.
- If awake for 10 to 15 minutes, get out of bed and do something quiet and relaxing (e.g., read a book in some place other than bed). Go back to bed only when sleepy. This helps the brain link the bedroom to sleep only.
- Keep a sleep diary to track habits and changes in sleep over time.

Cannabis

The widening legalization, availability, and social acceptance of cannabis has led to more frequent recreational and medicinal use of this drug by older adults. Sometimes, this results in cannabis use disorder (CUD). According to DSM-5, CUD includes symptoms such as:⁹⁰⁸

- Taking cannabis in larger amounts or over a longer period than was planned by the person.
- Having an ongoing desire to cut down or control use or past unsuccessful efforts to do so.

- Failing to fulfill major role responsibilities at work, school, or home because of cannabis use.
- Experiencing tolerance or withdrawal.

Withdrawal symptoms can lead to a return to use and include:⁹⁰⁹

- Irritability.
- Depression.
- Anxiety.
- Sleep problems.
- Dysphoria (sad mood).

Evidence-based treatments for CUD are lacking for the general population and for older adults. More studies and interventions designed for older adults are needed.

The National Institute on Drug Abuse recommends three behavioral approaches to treat CUD:⁹¹⁰ motivational interviewing (MI), CBT, and contingency management.

Stimulants

Stimulant intoxication (e.g., from cocaine or amphetamines) is linked to mental symptoms (e.g., anxiety, agitation, psychosis) as well as autonomic hyperactivity (i.e., high blood pressure, rapid heart rate). Benzodiazepines or neuroleptics may be prescribed for withdrawal-related symptoms, such as agitation and sleep issues (e.g., insomnia, extreme sleepiness).⁹¹¹ Other withdrawal symptoms can include:

- Depression.
- Irritability.
- Anxiety.
- Psychosis.

At this time, there are no FDA-approved, evidence-based pharmacological treatment options for individuals with cocaine use disorder⁹¹² and no approved treatments specific to older adults with stimulant use disorders. However, some pharmacotherapies have shown success in adult populations, including disulfiram, bupropion, and naltrexone.⁹¹³ **CBT remains the gold-standard treatment for stimulant cravings and return to stimulant use.**⁹¹⁴

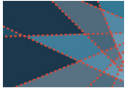
Psychosocial Treatment Approaches

Psychosocial interventions are generally effective in reducing and even stopping drug use and prescription medication misuse. Some interventions, such as CBT, MI, and relapse prevention therapy, are effective for many types of drug use.⁹¹⁵ Medication treatments for drug use may be more effective in combination with psychosocial treatment, compared with either medication or psychosocial interventions alone.^{916,917}

It is unclear which psychosocial treatments are most effective for older adults with drug use disorders. Some psychosocial approaches, like problem-solving therapy and CBT, have effectively treated older adults for other behavioral health issues (e.g., depression, tobacco addiction) that often co-occur with drug use disorders.^{918,919,920} A systematic review found that older adults do as well as or better than younger adults across SUD treatment approaches.⁹²¹

You can adapt standard psychosocial counseling methods for use with older adults by:

- Repeating information.
- Using a slower pace.
- Offering shorter sessions.
- Giving information in different ways (e.g., verbally, in large print) to match clients' level of physical and cognitive functioning.
- Using age-sensitive approaches with structured (not open-ended) questions. Such approaches are:
 - Supportive.
 - Nonconfrontational.
 - Responsive to gender/cultural differences.
 - Flexible (e.g., provide in-home or phone service for clients without transportation).
 - Focused on helping older adults learn/improve coping and social skills. (Chapter 4 of this TIP discusses CBT, MI, relapse prevention therapy, and problem-solving therapy treatment approaches for older adults in more detail.)



Age-Specific Treatment

Age-specific treatment approaches and practices help older adults seek, participate in, and complete treatment. Such approaches also improve older adults' treatment experience (Exhibit 5.5). Whereas some older adults benefit from mixed-age addiction treatment, those ages 75 and older or with more chronic co-occurring health conditions and functional limitations benefit from age-specific treatment.⁹²² Regardless of the treatment approach, older adults prefer age-specific, age-sensitive approaches that are nonconfrontational, person centered, and flexible.

Age-specific programming^{923,924} improves treatment completion and improves older adults' 12-month rates of abstinence. It also results in higher rates of attendance at group meetings compared with mixed-age treatment. Age-specific programs that have been studied have featured:⁹²⁵

- An emphasis on individual and group counseling and community activities.
- Adaptations such as slower pace and accommodations for vision, hearing, and cognitive impairment.

- Special topic groups for older adults focusing on:
 - Grief.
 - Loss.
 - Isolation.
 - Physical health issues.
 - Recreation.
 - Life changes.
 - Purpose.
 - Support.
- An emphasis on the therapeutic alliance while using CBT and MI, and a 12-Step philosophy.

Exhibit 5.5 highlights important characteristics of age-specific treatment for older adults recommended by the consensus panel.

Referral Management and Care Coordination

Limited time and resources may keep you from treating older adults with drug use disorders. However, as part of care coordination, you should develop linkages with treatment providers who

EXHIBIT 5.5. Age-Specific SUD Treatment for Older Adults

Accessibility

- Use a larger font on print and electronic client screening, assessment, and educational materials.
- Offer adaptations for individuals with cognitive, vision, or hearing impairments.
- Offer transportation, in-home services, and telephone checkups.
- Offer a sliding scale for self-paying clients.
- Use adaptations for individuals with physical disabilities and problems getting around.
- When needed, supply linkages to:
 - Food, clothing, and shelter.
 - Specialized medical services.
 - Older adult-focused social services.
 - Employment services.
 - Financial and housing assistance.

Program Specific

- Use a nonconfrontational manner emphasizing the therapeutic alliance while using therapeutic approaches that have been shown to work with older adults (e.g., CBT, MI, problem-solving therapy).
- Focus on building self-esteem and coping skills.
- Use a slower pace and adaptations for vision, hearing, and mild cognitive problems.
- Offer individual, group, and family counseling.
- Offer special topic groups for older adults.
- Give individual counseling and one-on-one attention.
- Ensure that staff are trained in the unique concerns and treatment needs of older adults.
- Use gender-specific content.
- Offer counseling with providers who specialize in geriatrics.
- Offer age-specific linkages to services within the community.
- Offer peer recovery support services geared to older adults.

can do so and with other resources within the community.⁹²⁶ (See “Resource Alert: Developing Referral Resources” in Chapter 2 of this TIP.)

Referring older clients to the right level of treatment and offering ongoing coordination of care are the keys to getting positive outcomes for older adults in addiction treatment.

Effective referral starts with matching your referral to the client’s stated goals and available resources. You must also address the client’s outlook and hopes for the referral.

Once you make a referral, follow up with both the client and the other provider to make sure that the client is continuing in treatment. Work together with the other provider to offer ongoing care as needed. (See Chapter 4 of this TIP for more strategies for referral management and care coordination.)

Recovery Management

Recovery management is an organizing philosophy for addiction treatment and recovery support services. Recovery management can help individuals and family members participate in treatment and achieve long-term recovery.⁹²⁷ Not everyone who uses illicit substances or misuses prescription medication needs ongoing recovery management support. However, **some older adults may need ongoing monitoring and recovery support**, especially if they have co-occurring medical conditions or mental disorders, experience social isolation, or receive little support from family and friends.⁹²⁸

Continuing care interventions that suit older adults and positively affect addiction treatment include:

- Home visits.
- Telephone counseling.
- Recovery checkups.
- Active linkage to community resources, such as recovery support groups.

Offering case management services and including supportive family members in the older adult’s treatment can also support ongoing recovery. (See also the “Family Involvement” section.)

Case and Care Management Services

Case and care management (CCM) services can help older adults reduce health-related risks of drug use or prescription medication misuse. The CCM approach to addiction treatment is broad. It addresses clients’ overall health and connects them to recovery resources within the community, such as NA and AA. CCM services focus on getting clients into addiction treatment programs when needed and linking them to other services, like:

- Housing support.
- Employment services.
- Financial services.
- Specialty medical treatment.

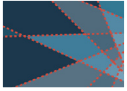
CCM services are commonly available in community-based agencies, healthcare offices, and residential or long-term care facilities.⁹²⁹ Addiction treatment programs and comprehensive behavioral health programs also may have care coordination and resource linkage services, which are increasingly offered by peer recovery support specialists.

CCM models can help older adults enter and stay in treatment, possibly because this approach seeks to reduce feelings of shame older adults often feel about entering treatment, and it provides support to the individual. CCM does this by focusing on older adults’ overall health rather than just their drug use.^{930,931} CCM strategies should help older adults gain access to age-related resources in the community that support recovery.^{932,933}

Family Involvement

Involving family throughout treatment and ongoing recovery can help improve older clients’ chances of staying in addiction treatment. It can also improve treatment outcomes. Family members:

- Often make first contact with treatment services.
- Can motivate the older adult to participate in treatment.



- Can help the older adult overcome barriers to access.
- Can help the older adult with the difficulties of the medical and specialized addiction treatment systems.
- Can provide important details about the client's history of and current substance use.

With the client's permission, involve family members and caregivers who support the older adult's recovery efforts:

- In the initial evaluation of the older adult.
- Throughout treatment.
- During ongoing recovery support.
- In posttreatment recovery plan development.

Although family members and caregivers can be key in providing support, they may also feel shame related to their family member's drug use disorder. You can help them feel more open to being involved by stressing that addiction is a chronic illness, like heart disease, and reminding them of the confidential nature of treatment. Without meaning to, sometimes family members exacerbate the older adult's drug use or prescription medication misuse by helping him or her get access to illicit substances or supporting the misuse of prescribed medication. Family members may benefit from psychoeducation, delivered in a nonjudgmental way, about the health risks of drug use and prescription medication misuse. (See Chapter 4 of this TIP for more information about family involvement in treatment and caregiver support resources.)

Mutual-Help Groups

Twelve-Step recovery support groups offer community-based support for individuals who have drug use disorders, including people who are in continuing care following brief interventions or specialized addiction treatment.⁹³⁴ A growing body of research suggests that mutual-help group participation improves long-term recovery, psychosocial outcomes, and self-efficacy.^{935,936}

However, no systematic studies address outcomes for older adults. Even so, **mutual-help group participation may improve recovery and help older adults reduce social isolation, shame, and the effects of discrimination associated with drug use disorders.**⁹³⁷

The key to linking older adults to mutual-help groups is finding available resources in your community and matching clients to specific groups that may be a better fit for older adults.

For example, when an older client cannot easily access an NA meeting, the client may benefit from attending AA meetings instead.⁹³⁸ Older clients may feel more comfortable going to AA than NA, where participants are typically younger and use multiple substances.⁹³⁹

Key elements of 12-Step groups that are especially well suited to older adults include:⁹⁴⁰

- General social support, goal direction, and structure.
- Participation in substance-free social activities.
- Activities to improve participants' self-efficacy and coping skills.

These strategies can help you link older clients to community-based recovery support groups:

- Become familiar with age-friendly mutual-help groups available in your community.
- Contact local support group offices and ask which meetings are accessible to people with disabilities and have active members who are older adults.
- Ask groups to provide contact information for older adult members who can act as temporary sponsors or provide transportation.
- Link clients to peer recovery support specialists in your own organization or in the community.
- Urge older clients to attend several different meetings before they decide whether mutual help is something they want to pursue, because each meeting has its own tone and feeling.

RESOURCE ALERT: SMART RECOVERY

SMART stands for Self-Management and Recovery Training. SMART Recovery is a network of local and online abstinence-focused addiction recovery support groups based on evidence-supported principles of CBT and MI approaches, which are appropriate for treating older adults. Unlike AA, NA, and Cocaine Anonymous, SMART Recovery meetings are run by trained volunteers and do not include a spiritual component. The SMART Recovery website (www.smartrecovery.org) offers information about SMART Recovery principles and training opportunities, including how to become a facilitator for meetings. It includes a searchable database of local and online meetings. You can also learn more about SMART Recovery in Chapter 4 of this TIP.

Clinical Scenarios

The clinical cases that follow give examples of substance misuse by older adults and ways to apply clinical interventions in these situations.

Interventions and treatments can range from PCPs asking the older adult about personal use of substances (e.g., benzodiazepines, cannabis, cocaine, alcohol use with medication misuse or illicit substance use) to inpatient addiction treatment. The level of intensity of interventions and treatments for older adults depends on:

- The substance used.
- The level of use.
- Effects on and risks to client.

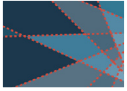
Clinical Scenario: Benzodiazepine Misuse and Polypharmacy

For many older adults, the relationship with their PCP is often one of their strongest and most stable. Visits to their PCP provide an opportunity to screen for substance use and misuse, including substance use related to late-life changes (e.g., retirement, moving, grieving a death). **This scenario demonstrates thorough screening of a new client and strategies for problem-solving and referral.**

- **Sedative, Hypnotic, or Anxiolytic Use Disorder:** An older adult woman becomes physically dependent on benzodiazepines after long-term use and increases her health risk by taking benzodiazepines with other sedative-hypnotic medications.
- **Treatment Setting:** Outpatient healthcare clinic
- **Providers:** PCP; clinical social worker (CSW)
- **Treatment Strategies:** Screen for alcohol misuse; discuss history of sedative use; provide information on risks of taking substances together; explore tapering off benzodiazepines; refer to CSW who uses CBT strategies for anxiety; follow up with the client.

Joan is a 70-year-old widow who has two grown children who live far away from her. She started to have significant anxiety in her 50s, when the company she worked for closed and her job ended. She was never able to look for or find a job again. At that time, she was prescribed a benzodiazepine by her PCP and she has taken it for many years. In the past year, her husband died, and she moved from her house to an apartment because she could not afford to stay in the house. She became more anxious and started taking extra doses of the benzodiazepine. Her sister also has a benzodiazepine prescription and has given Joan extra pills when she runs out, which happens more often lately. Joan has arthritis pain, making sleep difficult. To help with this, her doctor prescribed sleeping pills on a short-term basis. Joan stopped drinking alcohol when her husband stopped drinking 10 years before his death.

Her long-term PCP retired recently—another significant loss for Joan. She started seeing a new PCP at the same group practice after the nurse care manager reached out by phone to set up an initial consultation. Her new provider is screening all new clients for a variety of health behaviors. The PCP asks Joan about her alcohol use and notes that she has been taking benzodiazepines for more than a decade. Joan states, “I have been taking Xanax for years for my ‘nerves.’ It made it easier for me to go to social events and church after Jake died.” Joan also says that the pills make it a little easier to sleep but that she has recently had to take more sleeping pills to get any sleep at all. Joan likes her new doctor, so she is willing to talk



about her benzodiazepine dosage. She discusses how she gets some extra pills from her sister because she runs out before the prescriptions are ready to be filled and starts to feel “bad.”

At this meeting, the new PCP discusses Joan’s anxiety and, in a nonjudgmental way, gives information about the risks of taking benzodiazepines for a long time, taking more than prescribed, and adding sleeping pills to the mix. She says, “You know, many people who take this medication for a long time, even as prescribed, start to need a higher dose just to keep the anxiety at bay or then add a sleeping pill because the tranquilizer isn’t working anymore. There are some options we can talk about that could help you feel better without all of this medication. Can we discuss some options and figure out together what might work best for you?” Joan says that she would like not to have to take so many pills, and she worries that if her sister isn’t around, she won’t be able to get more tranquilizers from her.

The PCP and Joan discuss several options, including a long-term taper from the benzodiazepines, and work together to find the best option for Joan. The PCP explains the tapering process and explains how Joan can manage anxiety and sleep problems as she tapers off the medication. Initially, Joan is a bit nervous about tapering off the medication but agrees to this option after the PCP reassures her that she will work closely with her to make sure the taper is adjusted correctly for her situation.

The PCP then asks Joan whether she would be willing to talk to the clinic’s social worker about connecting with age-friendly activities in the community and learning to manage her anxiety without medication. Joan says “yes.” The PCP walks Joan over to the social worker’s office and introduces Joan to her. They set up an appointment for an initial visit.

The social worker is trained in CBT strategies to manage anxiety and introduces them to Joan at her initial visit. In their next session, the social worker discusses with Joan how the CBT is affecting her ability to manage anxiety. The social worker continues to see Joan weekly. Each week, Joan gets a structured, between-session assignment and a quick telephone reminder about practicing the exercise.

CBT FOR ANXIETY AMONG OLDER ADULTS

A review of psychosocial treatments for anxiety among older adults found that CBT had the strongest research support.⁹⁴¹ The authors reported that CBT could be even more useful for older adults when adapted to their needs. Some of these adaptations include:⁹⁴²

- Simpler CBT interventions.
- Between-session reminder phone calls.
- A weekly review of concepts discussed.
- At-home assignments.

The social worker also helps Joan connect with social activities she enjoys. With support, Joan feels she can improve how she feels physically and emotionally. Her PCP is in contact with Joan’s social worker and sees Joan on a regular basis to assess how well the taper is going and whether it needs adjustment.

Clinical Scenario: Use of Opioids and Alcohol for Pain Management

When older adults taking pain medication use alcohol, they can experience additional negative health effects. Older adults who live in retirement communities and long-term residential care facilities often find themselves in social situations where drinking is supported.⁹⁴³ Visits to the PCP provide a chance to screen for alcohol misuse as well as offer new options for pain management.

This scenario demonstrates screening thoroughly before prescribing additional pain medication, educating clients on the dangers of using alcohol with medication, and providing nonpharmacological pain management strategies.

- **ODU and Alcohol Misuse:** An older adult living in a retirement community who drinks to socialize becomes physically dependent on opioids after surgery.
- **Treatment Setting:** Outpatient healthcare clinic
- **Providers:** PCP; NP

- **Treatment Strategies:** Screen for prescription drug and alcohol use; discuss current health status of the client; provide information on risks of using alcohol while taking opioids; perform initial brief interventions; suggest physical therapy and a tapering program; conduct multiple follow-up brief interventions and calls with the client.

Louise is a 75-year-old retired middle school teacher who is married. She and her husband, a retired high school principal, just celebrated their 50th wedding anniversary. They have a son, a daughter, and three grandchildren. For the past 5 years, they have lived in a retirement community. They have made friends in the community and take part in activities, including golf, exercise classes, card games, and book clubs. Many of these events include alcohol. In addition, the community sponsors regular happy hour gatherings at the clubhouse that Louise and her husband also attend.

One month ago, Louise had knee replacement surgery. She began taking opioids for pain in the hospital and was sent home with a prescription so that she could continue to use the medication during rehabilitation. She was still having pain during the day, with greater pain at night. To add to the effects of the opioids and make them “go further,” she drank wine at the usual get-togethers with friends and had additional drinks in the evening before bed. A neighbor, Pat, had prescription opioids from a past surgery. She offered them to Louise to help “tide her over” until she saw her doctor. Louise waited to make an appointment until she was almost out of her neighbor’s opioid medication.

Louise makes an appointment with her PCP to see whether she can get more pain medication. She tells her PCP that the pain is not going away, and that she is almost out of medication. The PCP talks with Louise about her pain and screens for amount and frequency of alcohol use and medication use. He discovers that she is drinking while taking the opioids and has been using more opioids than recommended. He then gives her nonjudgmental feedback about the results of the screens. He says, “Based on your answers to my questions about your alcohol use and use of pain medication, it looks like you are at risk for some serious health

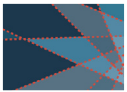
problems if you continue drinking alcohol and taking medication in this way. We know that when people your age drink and take the kind of pain medication you are on, they can have problems with their breathing, ability to move around, or memory. Are any of those happening to you?” Louise starts to become concerned and responds, “You know, I have been getting more confused about things lately and feeling like I sometimes have a hard time breathing easily. But I am worried about the pain and how I will manage without pain medicine or extra alcohol.”

The PCP acknowledges her concerns by stating that maintaining her health and level of activity is important. The PCP asks whether she would be willing to work with him and an NP to come up with a plan to manage her pain while lowering the health risks she faces by drinking and using pain medication at the same time. Louise says, “Well, what’s most important to me is to get my knee in good shape again.”

The PCP supports Louise’s goal and calls in the NP, who is trained in giving substance-related brief interventions and has worked with other clients to help them cut back on alcohol and reduce or stop their use of opioids. The NP schedules Louise for two face-to-face meetings and two follow-up phone calls between visits. She and Louise develop a treatment plan that includes Louise going to physical therapy and a rehabilitative exercise class in her community to help her knee heal and improve her range of motion so she can get back to golfing with her group. Louise also agrees to keep track of her alcohol use and to follow an opioid taper plan over the next month to get off the pain medication.

Clinical Scenario: Screening, Assessment, and Referral to Addiction Treatment

Older adults with a history of substance misuse have increased risk of return to substance use when they have additional stressors (e.g., injury, divorce, family conflict). Heavy substance use also leads to many health problems; these are often the primary reason a client seeks treatment or winds up in the ED. A study found that SBIRT in an ED setting was a factor in reducing substance use at follow-up, suggesting that an ED visit for another medical



problem may be a “turning point” for many individuals with substance misuse concerns.⁹⁴⁴ **This scenario shows the importance of the ED as a setting for screening, assessment, and referral; it also demonstrates strategies providers can use to take advantage of “teachable moments” with clients.**

- **Cannabis and Alcohol Misuse:** An older adult with a long history of alcohol and cannabis misuse has co-occurring medical conditions.
- **Treatment Setting:** ED of a community hospital
- **Provider:** ED attending physician
- **Treatment Strategies:** Get the client medically stable; order a blood test screen for alcohol; order a urine screen for cannabis; discuss the current state of the client; provide information on the risks of using alcohol with cannabis; conduct a brief intervention; recommend short-stay, inpatient detoxification and treatment followed by outpatient care.

Walter is 69 years old and divorced. He lives with his girlfriend. He has an adult son and a granddaughter. Walter likes to hunt and fish with his male friends but has little other social contact. Walter had some problems with alcohol when he was younger, including being arrested for driving under the influence. He cut back on drinking but started smoking cannabis daily. After he got married, he stopped using cannabis and drank only occasionally for several years. He started drinking heavily and smoking cannabis again after an on-the-job back injury in his early 50s. He divorced 10 years ago and retired the next year. He met Sally, his long-term girlfriend, 5 years ago. Walter drinks heavily and uses cannabis daily. In the past year, there have been many times when he did not remember what he did when he was intoxicated. His girlfriend used to enjoy smoking cannabis and drinking with him, but as he increased his use, she is no longer comfortable living with him and has threatened to move out if he keeps using.

Walter has been having some health problems, including high blood pressure, diabetes, and chronic back pain. He sometimes forgets to take his medications. He was stopped by the police for unsafe driving recently but was not arrested.

In addition, he had a falling out with his son and daughter-in-law. They do not want him spending time with his granddaughter because he is often drunk and high.

A week later, he starts drinking and smoking cannabis when he wakes in the morning and continues to use all day, passing out in the late afternoon. When he awakens a few hours later, he has chest pain, nausea, and sweating. Worried of a heart attack, his girlfriend takes him to the ED. The attending physician sees him immediately, takes a medical history, and orders lab tests to rule out a heart attack. However, a blood draw shows his blood alcohol level is 0.18. A urine screen is positive for cannabis. The ED physician then performs a more indepth screen and assessment of Walter’s substance use history and, with Walter’s permission, invites Sally to discuss the effects of Walter’s drinking and cannabis use.

Once Walter is less intoxicated, the ED physician talks with him about his medical status. In a nonjudgmental and nonconfrontational tone, he says, “Walter, the good news is that you did not have a heart attack. Based on your other lab tests, your age, and other medical conditions and what you and Sally have told me about your drinking and cannabis use, I want you to think about a short stay at an inpatient treatment program so you can get a handle on your substance use.” At first, Walter is not sure, but then Sally supports him. He then says, “I feel so sick, and thinking I was having a heart attack really scared me. I guess it’s the best thing for me to do.” The ED physician introduces Walter and Sally to the nurse care manager and assures them that she can answer any questions they have about the treatment process and will help transfer his care to the inpatient program.

Clinical Scenario: Polysubstance Misuse With Co-Occurring Medical Conditions

More and more older adults with a history of illicit drug use, particularly heroin and cocaine, are being admitted to inpatient addiction treatment programs.^{945,946} Cocaine use in older adults is related to multiple medical problems, including higher rates of high blood pressure, breathing issues, heart attack, stroke, and cognitive

impairment.⁹⁴⁷ Older adults with a long history of polysubstance misuse (misuse of multiple substances at the same time) and co-occurring medical conditions are at risk for return to substance use and lack of follow-up for medical conditions after inpatient treatment. **This scenario demonstrates referral management and ongoing recovery support strategies for an older adult with a history of polysubstance misuse and co-occurring medical conditions.**

- **Polysubstance Misuse:** An older adult has a history of misuse of heroin and cocaine.
- **Treatment Setting:** Inpatient detoxification and rehabilitation program
- **Provider:** Licensed alcohol and drug counselor (LADC) on a multidisciplinary treatment team
- **Treatment Strategies:** Offer referral and recovery management strategies before discharge.

Hal is 74 years old and never married. He started using heroin as a soldier in the Vietnam War. After discharge from the service, he started using cocaine to stay awake during his night shift at the post office. His drug use stayed about the same for many years but increased after he retired. He lives alone, and his social life includes playing poker with friends on Thursdays. During a recent game, Hal had numbness in his arm and slurred speech. One of his buddies brings him to the ED. Hal is having a mild stroke. After he is medically stabilized, Hal enters an extended-care inpatient SUD treatment program. After 8 weeks of treatment, Hal meets with his primary counselor to discuss his continuing care plan.

ADAPTING RESIDENTIAL CARE FOR OLDER ADULTS

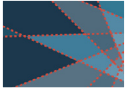
Because many older adults have problems getting around, upon admission to residential and inpatient programs, older adults can benefit from being paired with a “senior buddy” to help them learn the facility and move from one treatment activity to another.⁹⁴⁸

The counselor opens the conversation by saying, “Hal, you’ve done really well in treatment. You’ve participated fully in therapy and educational groups here and have a solid plan to keep yourself from relapsing and to help you cope with any triggers to use once you go home.” Hal responds, “Thanks. It’s good to hear that you think I’ve been doing well. Frankly, I was kind of anxious when I was first admitted to the program. It really helped that you paired me up with Bill to show me the ropes.”

The counselor says, “Let’s talk about your goals for ongoing recovery.” Hal says he doesn’t want to go back to using but worries that he has no recovery support back home. He says, “My poker buddies all drink and smoke pot. Even though that wasn’t my thing, I think that will be a trigger to use again. I liked the NA meetings a lot, but I live in a really small town, and there aren’t any NA meetings nearby.”

Hal’s counselor had already contacted the AA central service office closest to Hal and gotten the names and contact information of an older AA volunteer who would be willing to help Hal get to meetings and act as a temporary sponsor. The counselor says, “I already talked to Jerry. It turns out he is a Vietnam vet, too.” Hal says that talking to someone who has “been there” would be a big help to him.

Hal and his counselor talk about other recovery management options, like linking with a counselor and a continuing care group at an outpatient SUD treatment program nearby and getting Hal an appointment with a PCP who can provide medical care. The counselor tells Hal of a recovery checkup program with a peer recovery support specialist who will call him regularly to see how he is doing and whether he needs linkage to other community resources. The counselor will provide a “warm handoff” by introducing Hal to the specialist before discharge. Hal says, “That sounds great. It will be nice to have that connection to the rehab.” Hal and his counselor write down his continuing care plan and all contact information. His counselor says, “Your homework is to call the AA contact and schedule a meeting after your discharge on



Thursday. Mine is to make referrals to the PCP and outpatient addiction counseling program.” Hal is satisfied with the recovery plan and motivated to follow through and continue his recovery program.

Summary

Widespread screening, brief intervention, and referral and recovery management are essential to the successful treatment of drug use and prescription medication misuse, including drug use disorders, in older adults. Whatever specific treatment method or strategy you use when working with older adults who have drug use disorders, make sure it is nonconfrontational and age sensitive. Ongoing recovery management strategies increase the chance that improvements will continue over time and not only help older adults reduce negative drug-related health and behavioral outcomes, but also improve the quality of their lives.

Chapter 5 Resources

Provider Resources

National Council on Aging—Resources (www.ncoa.org/audience/professional-resources/?post_type=ncoaresource): This resource provides a searchable database of articles, webinars, and manuals.

Consumer Resources

FindTreatment.gov (<https://findtreatment.gov>): People seeking treatment for SUDs can use this federal locator maintained by SAMHSA to find treatment facilities based on location, availability of treatment for co-occurring mental disorders, availability of telemedicine care, payment option, age, languages spoken, and access to medication for OUD. The site also links to information on understanding addiction, understanding mental illness, and paying for treatment.

SAMHSA—Behavioral Health Treatment Services Locator (<https://findtreatment.samhsa.gov/>): SAMHSA offers people seeking treatment for addiction or mental illness a confidential, anonymous information source about treatment facilities in the United States and U.S. Territories.

SAMHSA’s National Helpline (www.samhsa.gov/find-help/national-helpline): The National Helpline is a free, confidential, 24/7, 365-days-a-year treatment referral and information service (in English and Spanish) for people facing mental disorders and SUDs. The toll-free phone number is 1-800-662-HELP (4357) or 800-487-4889 (TTY).

Faces & Voices of Recovery—Guide to Mutual Aid Resources (<https://facesandvoicesofrecovery.org/resources/mutual-aid-resources>): Visitors can find a listing of mutual-help group contact information.