

Chapter 3—Identifying, Screening for, and Assessing Substance Misuse in Older Adults

KEY MESSAGES

- Behavioral health service and healthcare providers in any setting should screen older clients for substance misuse. Many different healthcare providers can play a role in this. There is no “wrong door” through which older adults can arrive at the right diagnosis and care.
- The main reason for screening and assessment is to help you decide whether, where, and how to address substance misuse.
- Substance misuse affects older adults differently than it does middle-aged and younger adults. Providers across settings should be trained in giving age-appropriate care. They also need to have the skills to recognize substance misuse in older clients.

Chapter 3 of this Treatment Improvement Protocol (TIP) will most benefit providers. It discusses identifying, screening for, and assessing substance misuse in older clients. In the United States and elsewhere, more and more people ages 50 and older struggle with substance misuse, but many providers do not screen for, diagnose, or treat substance use disorders (SUDs) among this population.

OLDER ADULTS are less likely to be screened for **SUBSTANCE MISUSE** and more likely to be taking **MULTIPLE** medications.



Older adults are less likely than younger adults to receive screening and assessment for substance misuse.²⁸⁸ This is potentially dangerous because, as people age, they are more likely to feel the negative effects of drugs and alcohol. Older adults are also more likely to take multiple medications, which means they may face dangerous and potentially fatal drug–drug interactions. Furthermore, identifying substance misuse in older adults is not simple. The signs and symptoms of substance misuse can be easily mistaken for normal aging or physical or mental disorders common in older populations.

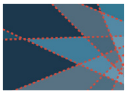
Even so, substance misuse is detectable and treatable among older adults. Yet if left untreated or poorly treated, it can shorten their lives and keep them from living healthily and independently. For example, substance misuse increases the risk of falls, cognitive impairment, overdose, heart disease, high blood pressure, certain cancers, HIV, hepatitis, cirrhosis, and mental disorders.^{289,290}

This chapter of TIP 26 will help behavioral health service providers, social service providers, and other healthcare providers who work with older adults better understand how, when, and why to use screening and assessment to address substance misuse in their older clients.

Who Can Benefit From Chapter 3 of This TIP and How?

Chapter 3 will support behavioral health service and healthcare providers who work with older adults in overcoming barriers to identifying, screening for, and assessing substance misuse in older clients by helping these providers:

- Recognize early warning signs of substance misuse in older adults.



- Understand the relationship between substance misuse and depression, anxiety, trauma, and problems with thinking (also called cognitive impairment).
- Become more aware of common myths about substance misuse in older adults.

Who in the geriatric workforce should be identifying, screening for, or assessing substance misuse in older adults? Nearly everyone! The Institute of Medicine report *The Mental Health and Substance Use Workforce for Older Adults: In Whose Hands?*²⁹¹ notes that the full range of providers should help meet the needs of older adults who misuse substances. These providers include:

- Mental health service and SUD treatment providers, including psychiatrists, psychologists, social workers, psychiatric nurses, and addiction counselors.
- Primary care providers, general internists, family medicine practitioners, trained pharmacists, advanced practice registered nurses, and physician assistants.
- Geriatricians, geriatric nurses, geriatric psychiatrists, geropsychologists, and gerontological social workers.
- Direct care workers who provide in-home support services.
- Peer recovery support service providers.
- Informal and formal caregivers.
- Supports within the faith community.
- Social service providers.

Chapter 3 will be useful across settings in which these workers encounter older adults. No single service provider or setting is solely responsible for making sure older adults receive the substance use-related care they need. However, all providers and settings can fulfill an important role.

Organization of Chapter 3 of This TIP

Chapter 3 offers a wide range of information and strategies to help you screen, assess, and treat older clients for substance misuse.

The first section of Chapter 3 is about the challenges to screening and assessing older clients for substance misuse. It also discusses why you need to screen and assess these clients. You will be more likely to use screening and assessment once you understand why they are so important. In the end, this will help your clients increase their chances for recovery.

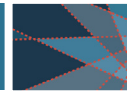
The second section discusses how to screen for substance misuse in older adults. Screening for substance misuse also includes screening for co-occurring mental and neurocognitive disorders that can affect (and are affected by) substance use, such as depression, anxiety, posttraumatic stress disorder (PTSD), and dementia. Knowing why, how, and whom to screen for substance misuse and co-occurring mental or neurocognitive disorders will help you provide more complete care. It also increases the chances of clients receiving the correct diagnosis and needed treatment.

The third section describes how to use brief assessments—an important follow-up to screening—for clients who screen at risk for substance misuse and co-occurring mental or neurocognitive disorders. Brief assessment helps make or rule out diagnoses and aids you and your clients in making appropriate shared treatment decisions.

The fourth section describes how to fully assess older adults who screen positive for moderate-to-severe substance misuse. A full assessment does more than just ask clients about substance use. It also asks about their overall health and well-being. This will give you a more complete picture of your clients' substance-related issues and will help you understand how substance misuse affects them.

The fifth section guides providers in treatment planning, treating, or referring for treatment. Knowing how and why to screen and assess is only half the picture. Understanding what steps to take in offering effective care or referral for care is a cornerstone of good clinical practice.

The final section identifies targeted resources to support your practice, from screening to referral. A more detailed resource guide is available in Chapter 9 of this TIP.

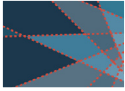


For definitions of key terms you will find in Chapter 3 of this TIP, see Exhibit 3.1.

EXHIBIT 3.1. 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-specific:** Treatment approaches and practices specifically developed for older adults (e.g., an older adult specialty group in a mixed-age SUD treatment program).
- **Alcohol misuse:** The use of alcohol in any harmful way, including heavy drinking, binge drinking, and alcohol use disorder (AUD).
- **At-risk/high-risk drinking:** Drinking alcohol in excessive amounts. This definition encompasses both binge drinking and heavy drinking. Additionally, any alcohol consumption is considered risky when carried out by individuals with certain medical conditions that are worsened by alcohol, those taking medicine that can interact harmfully with alcohol, those driving a car or engaged in other activities that require alertness, or people recovering from AUD.^{292,293} Note that for purposes of this TIP, at-risk drinking and high-risk drinking are synonymous, and either term is acceptable to describe an older adult's drinking patterns.
- **Binge drinking:** A drinking pattern that leads to blood alcohol concentration levels of 0.08 grams per deciliter or greater. This usually takes place after four or more drinks for women and five or more drinks for men.^{294,295} However, older adults are more sensitive to the effects of alcohol, and treatment providers may need to lower these numbers when screening for alcohol misuse.²⁹⁶ Additionally, other factors such as weight, decrease in enzyme activity, and body composition (e.g., amount of muscle tissue present in the body) can also affect alcohol absorption rates.
- **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.²⁹⁷ 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.
- **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.²⁹⁸
- **Heavy drinking:** Consuming five or more drinks for men and four or more drinks for women in one period on each of 5 or more days in the past 30 days.²⁹⁹
- **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).
- **Moderate drinking:** According to the 2015–2020 *Dietary Guidelines* for Americans, moderate drinking is defined as up to two drinks per day for men and up to one drink per day for women.^{300,301} However, the Centers for Disease Control and Prevention (CDC) notes that these numbers apply to any given day and are not meant as an average over several days.³⁰² Additionally, individuals who don't metabolize alcohol well may need to consume even lower quantities. Some people, particularly those with certain alcohol-related illnesses or engaging in tasks requiring concentration, should not consume alcohol at all. The *Dietary Guidelines* stipulate that those who don't drink should not begin drinking for any reason.³⁰³

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- **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.³⁰⁴
- **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, prosocial 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).³⁰⁵ Remission is an essential element of recovery.
- **Screening:** A process for evaluating the possible presence of a specific problem. The outcome is normally a simple yes or no.
- **Screening, brief intervention, and referral to treatment (SBIRT):** An evidence-based, comprehensive, integrated public health approach to identify, reduce, and prevent misuse of and dependence on alcohol and illicit drugs.
- **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-5,³⁰⁶ 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>).

Challenges to Identification, Screening, and Assessment

Some health experts have called older adults who misuse substances an “invisible” population.^{307,308} Although older adults have frequent medical visits, behavioral health or healthcare providers often do not recognize substance misuse in their older clients.

Older clients are less likely than younger clients to tell you that they are having a problem with substance use and are less likely to ask for treatment.³⁰⁹ Some barriers older adults face are unique to their population. **Older adults’ substance misuse can stay “hidden” when:**³¹⁰

- **Providers believe that older clients do not have alcohol or drug problems later in life.** (“Drug use is a young person’s problem.” Or, “No one starts abusing alcohol in their 60s.”)
- **Providers have negative thoughts and attitudes about aging.** This is also called ageism. (“Talking about drugs and alcohol with someone who is older is a waste of time.” Or, “He’s 83 years old and has been drinking his whole life. He’s never going to change, so why bother?” Or, “Older people are less likely to change or benefit from treatment.”)
- **Providers feel uncomfortable talking about substance use and misuse with older adults.** (“Given his age, I don’t want to be disrespectful or tell him what to do.”)
- **Family members feel uncomfortable asking an older relative to stop using substances—especially alcohol.** (“I’d rather not ask Mom to stop drinking. I’d be taking away her one last pleasure in life.”)
- **Providers lack knowledge about drug and alcohol screening and assessment tools.** (“I don’t know the first thing about how to look for addiction problems in older clients.”)
- **Providers and family members misunderstand the difference between symptoms of substance misuse and similar symptoms of physical and cognitive decline or mental illness common in older populations.** Such problems include dementia, pain, anxiety, and depression. (“At her age, it’s normal to forget people’s

names. Drinking has nothing to do with it,” or, “Dad’s not depressed; he just lost his ‘pep’ in getting older.”)

- **Providers believe that they don’t have enough time to give screening and assessment measures.** (“I barely have time to see all my clients. There’s just no time for screening and assessment.”)
- **Older adults experience substance-related functional impairment,** which providers may have a hard time detecting in older clients who no longer work, drive, or have significant obligations to others professionally or at home.
- **Older adults seek services in nontraditional addiction treatment settings.**
- **Providers spend too little time with clients (and older adults in particular).**

To remove these barriers, providers need education and skills training aimed at helping them better recognize possible substance misuse in their older clients.

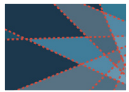
To spot substance misuse in older clients as early as possible, tailor your approach to working with them:

- Be aware of your beliefs about/attitudes toward older clients that make you not screen for substance misuse.
- Choose a method for drug and alcohol screening that you can use with all older clients.
- Use an interview style that older clients will find comfortable (e.g., supportive).
- Train counselors on how to spot substance misuse early.

Screening for Substance Misuse in Older Adults

Substance misuse is common among clients seen in healthcare³¹¹ and behavioral health service settings. Although most older adults do not misuse substances, some do. Consider these facts, which show that **substance misuse does occur in older people:**

- In 2019, estimates showed that 4.7 million adults ages 50 and older had a past-year SUD.³¹²



- In 2019, an estimated 8.8 million adults ages 50 and older reported using an illicit drug in the past month.³¹³
- In 2019, more than 56 million adults ages 50 and older were estimated to have engaged in past-month alcohol use.³¹⁴
- The rate of prescription opioid misuse among older adults (ages 60 and older) is lower than among younger adults (ages 20 to 59), but from 2006 to 2013, older adults increasingly misused prescription opioids with suicidal intent and showed an increasing trend in death rate.³¹⁵

Know the different types of prescription medications older clients may misuse. These include:

- **Sedative-hypnotics:** These medications are often used to help people relax or sleep. They include barbiturates (like amobarbital and secobarbital) as well as benzodiazepines (like lorazepam and alprazolam).
- **Opioid analgesics:** These medications are often prescribed to provide pain relief by attaching to opioid receptors in the brain. Examples include oxycodone and hydrocodone.

Why, When, and How To Screen

The TIP consensus panel recommends that addiction treatment, other behavioral health service, and healthcare providers screen for alcohol, tobacco, prescription drug, and illicit drug use in all older clients at least annually. The TIP consensus panel recommends performing universal screening during health visits.

Screening and assessment are very important steps in diagnosing substance misuse and making the right care decisions. **Screening can help you answer the following important questions:**

- **Does my client need an assessment?** Although the two terms are often confused for one another, “screening” is not the same as “assessment.”
- **Screening** is the process of evaluating whether symptoms of substance misuse are present. Screening helps you decide whether further assessment is necessary.

- **Assessments** give detailed information for diagnosis, treatment decisions, and treatment planning.
- **Is my client’s substance use potentially harmful?** Screening can help you learn whether a client’s alcohol or drug use could be harmful because of an existing condition or use of prescription medications. In some cases, any substance use at all may be harmful. Many older clients have chronic medical illnesses and take more than one prescription medication. Combining drugs and alcohol with medications can be dangerous and even lead to death. Drug and alcohol use can also make certain illnesses worse and keep clients from feeling their best.
- **Does my client seem afraid to ask for help?** Screening is necessary because older clients are less likely than younger clients to ask directly for help.³¹⁶ However, older adults are diverse, and older adults from the baby boomer generation (birth dates 1946 through 1964) may be more willing to discuss SUD and mental illness with their healthcare providers than earlier generations. Screening is helpful when clients feel afraid or ashamed of revealing their problem spontaneously.

SUDs are chronic conditions. You can help older clients feel less shame and stigma by talking about substance misuse in the same way you would a mental disorder, like depression or anxiety. Use basic terms rather than confusing or judgmental language. Be sure to also ask about their overall health, functioning, and well-being. This shows clients that you are concerned and feel empathy for them rather than making them feel like their substance use is a consequence of weak willpower or a personal flaw.

- **My client doesn’t seem to meet diagnostic criteria for an SUD. Could this person still be misusing substances?** Screening is initially more useful than relying solely on DSM-5 diagnostic criteria. Most older adults who misuse substances do not meet full DSM-5 criteria for a specific SUD but may be engaging in risky use of substances. This is because several key criteria are not typically present in older adults.

For example, older adults have lower tolerance for substances like alcohol than younger and middle-aged adults and may experience harmful effects at lower amounts of consumption than younger adults. Compared with younger and middle-aged adults, older adults are significantly less likely to endorse the *Diagnostic and Statistical Manual of Mental Disorders*, 4th Edition (DSM-IV) alcohol abuse criterion for alcohol use in “physically hazardous” situations.³¹⁷

- **Does my client need SUD treatment?**
Screening can lead to earlier treatment, and thus, better health.³¹⁸

The U.S. Preventive Services Task Force (USPSTF) recommends that healthcare providers screen for unhealthy alcohol use in adults age 18 years or older and provide people engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce unhealthy alcohol use (www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryDraft/unhealthy-alcohol-use-in-adolescents-and-adults-screening-and-behavioral-counseling-interventions).

Chapter 3 will help you decide which screening tools to use, how and when to administer them, and who should do so. Every practice should select screening tools and develop procedures for who will give the screenings and when to give them. You can select screening measures based on which substances you want to ask about (Exhibit 3.2). Be aware that not all of these measures have been validated—in other words, tested and approved for use—in older adults. Your practice should also identify steps to take when screening tests are positive (see the section “Communicating Screening Results”).

No screeners have been statistically validated for assessing prescription or over-the-counter (OTC) medication misuse that would identify accidental misuse or noncompliance issues. Nevertheless, healthcare and behavioral health service providers should assess how older adults

use such medications, with an eye toward potential adverse reactions and interactions. **The American Geriatrics Society’s 2019 Beers Criteria® address medications that are potentially inappropriately prescribed for older adults.**³¹⁹ See the Chapter 6 text box on the 2019 Beers Criteria®.

EXHIBIT 3.2. Drug and Alcohol Screening Tools

Alcohol:

- Alcohol Use Disorders Identification Test (AUDIT)
- Alcohol Use Disorders Identification Test-C (AUDIT-C)
- Short Michigan Alcoholism Screening Test-Geriatric Version (SMAST-G)
- Senior Alcohol Misuse Indicator (SAMI)

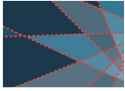
Cannabis:

- Cannabis Use Disorder Identification Test-Revised (CUDIT-R)

Multiple substances:

- Alcohol, Smoking, and Substance Involvement Screening Test (ASSIST)
- Brief Addiction Monitor
- CAGE Adapted to Include Drugs (CAGE-AID)
- National Institute on Drug Abuse (NIDA) Quick Screen V1.0

Screen older clients for substance misuse at intake. Screen regularly, before starting new medication, and when potentially substance-related problems arise, such as injury or accidents. Have clinical assistants administer screening instruments in an interview or as part of other health screenings. **Provide a paper or digital tablet version for clients to complete by themselves.** USPSTF recommends **electronic screening and brief intervention as an effective strategy** to prevent excessive alcohol use.³²⁰ Some older adults may not be comfortable using computers or tablets. Others may have difficulty reading or writing. Be sensitive to each client’s skills and abilities when selecting screening formats.



Review screening results and discuss them with clients. Help clients understand their risk levels and the consequences of substance misuse. Gauge motivation and readiness for change. Keeping an open, nonjudgmental attitude will help your clients feel more comfortable sharing more information with you.

Make sure you have the required training and credentials or licensure before performing screening, assessment, or diagnosis. If no providers in your program have appropriate licenses or credentials to screen, assess, or diagnose clients for mental disorders, refer clients to another program for those needs. Also make sure you review the training requirements on administration and scoring; formal training may be required prior to using some instruments. When formal training is unnecessary, learn how to give each screening measure and assessment; instructions and scoring may vary depending on population demographic features and other factors.

Federal guidelines for moderate drinking are as follows:^{321,322,323}

Overall consumption that minimizes risk and can help avoid alcohol-related problems includes:

- No more than one standard drink a day for women and no more than two standard drinks a day for men.
- These numbers apply to any given day and are not meant as an average over multiple days.

However, guidelines do not recommend that individuals who do not drink alcohol start drinking for any reason.³²⁴

Older adults should not drink any alcohol if they:

- Are taking alcohol-interactive prescription medications, especially psychoactive prescription medications (e.g., opioid analgesics, benzodiazepines).
- Have medical conditions that can be made worse by alcohol (e.g., diabetes, heart disease).
- Are planning to drive a car or participate in other activities requiring alertness and skill.
- Are recovering from AUD.

Substance Misuse Screening Measures Appropriate for Use With Older Adults

This section discusses examples of substance misuse screening instruments useful for older adults. A full selection of screening resources appears in the Chapter 3 Appendix. Many tools described here were developed specifically for older adults. Some are self-report tools (i.e., clients complete the tools themselves); a behavioral health service provider must deliver others. Older clients may have limited vision or difficulty writing and may need help completing screens.

Alcohol Screening

USPSTF recommends screening adults for alcohol misuse,³²⁵ including screening for risky drinking and AUD **with brief instruments like the AUDIT-C**. USPSTF also recommends brief counseling for clients who engage in risky drinking.^{326,327}

A very brief “prescreen,” especially for alcohol misuse, can be easily incorporated into healthcare clinic or social service agency screening protocols. A short prescreen is not burdensome as a universal screening tool. However, many clients will be ruled negative for problematic use. If results are positive, more comprehensive assessments can be administered to determine severity and make treatment recommendations.

For more information about alcohol screening, see the “Screening and Assessment” section in Chapter 4 of this TIP.

AUDIT

The AUDIT was developed to screen for heavy alcohol use. It can reveal alcohol misuse in people ages 65 and older.³²⁸ The first three AUDIT questions measure alcohol intake and are known as the AUDIT-C. Use the AUDIT or the AUDIT-C to get more detailed information from clients who use alcohol. The AUDIT has demonstrated reliability in studies of AUD screening.³²⁹ The AUDIT (self-report version) and the AUDIT-C are available in the Chapter 3 Appendix.

SAMI

The SAMI³³⁰ is a five-item questionnaire for older adults who may engage in risky alcohol use. This questionnaire includes a checklist of symptoms and open-ended questions about alcohol use.³³¹ A score of 1 or higher suggests problem alcohol use. The SAMI is available in the Chapter 3 Appendix.

SMAST-G

The SMAST-G is the first brief alcohol misuse screener developed for older adults. If a client marks two or more items on the SMAST-G with a “yes” response, that suggests potential alcohol misuse.³³² The SMAST-G is available in the Chapter 3 Appendix.

Cannabis Screening

CUDIT-R

The CUDIT-R³³³ measures cannabis misuse in the past 6 months. Developed from the AUDIT measure, it is a short version of the 20-item CUDIT screener. A score of 12 or higher means you should assess for cannabis use disorder. Yet this cutoff score has not been tested thoroughly. Do not assume that a score below 13 means the client does not misuse cannabis.³³⁴ The CUDIT-R is available in the Chapter 3 Appendix.

Screening for Multiple Substances

ASSIST

ASSIST screens clients for all categories of substance misuse, including alcohol and tobacco (see “Resource Alert: The ASSIST Screener”). This World Health Organization (WHO) screener also measures substance-specific risk. Many providers do not use the ASSIST because it is long and somewhat hard to score. A computer version and a shorter version (ASSIST-Lite; see <https://eassist.adelaide.edu.au/#/eassist-lite> for a computer version) are available and easier to use.^{335,336,337}

RESOURCE ALERT: THE ASSIST SCREENER

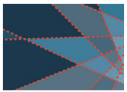
The full version of WHO’s ASSIST screener, scoring system, and client feedback guidance can be downloaded in multiple languages (www.who.int/substance_abuse/activities/assist_test/en).

Brief Addiction Monitor

The Brief Addiction Monitor is a 17-item scale originally made for the Veterans Health Administration healthcare system.³³⁸ **It can indicate the severity of a client’s substance misuse and show how people in treatment or recovery are doing.**³³⁹ The Brief Addiction Monitor asks about risk factors for substance misuse (e.g., craving, family or social problems) as well as factors that protect against substance misuse (e.g., social supports for recovery, religion or spirituality). This instrument is available at www.mentalhealth.va.gov/communityproviders/docs/bam_continuous_3-10-14.pdf.

CAGE-AID

The CAGE (Cut down, Annoyed, Guilty, Eye opener) Questionnaire is widely used to screen for risk of alcohol misuse. A similar version, **the CAGE-AID,³⁴⁰ asks about substance misuse.** A “yes” response on any of the questions can mean substance misuse is present. However, the CAGE-AID does not ask about certain important aspects of substance use, including past substance use, frequency of use, and effects of using the substance. The CAGE-AID should be used with, but not in place of, longer and more detailed alcohol and drug screeners. It is available at www.hiv.uw.edu/page/substance-use/cage-aid.



NIDA Quick Screen V1.0

The NIDA Quick Screen V1.0 is a brief screener that asks about a client's past-year use of alcohol, tobacco, prescription drugs (nonmedical use), and illegal drugs. If a client answers "yes" to the question about using illegal drugs, follow up by giving a slightly longer screening tool called the NIDA-Modified ASSIST V2.0. Both tools are available on NIDA's website (www.drugabuse.gov/sites/default/files/pdf/nmassist.pdf).

Screening for Co-Occurring Disorders and Conditions

Co-Occurring Mental Disorders

Many older people who misuse substances also have co-occurring mental disorders. Some of these disorders, like major depressive disorder (MDD), anxiety, and PTSD, have symptoms similar to those seen in substance misuse and in cognitive impairment. You might at times have difficulty telling these conditions apart from one another. Co-occurring mental disorders can make substance misuse worse or result from substance misuse. You might be surprised to learn that:

- In 2019, approximately 1.7 million U.S. adults ages 50 and older had an SUD and a mental disorder.³⁴¹
- Approximately 36.8 percent of adults older than age 50 with SUDs also have mental disorders, and 10.7 percent of adults over 50 with mental disorders also have SUDs.³⁴²
- SUDs in older adults often occur alongside depression and other affective disorders, psychosis, and cognitive disorders (e.g., dementia).^{343,344}
- Older people with serious mental illness (SMI; complex mental disorders like bipolar disorders and schizophrenia) are especially likely to misuse substances compared with older adults without SMI,³⁴⁵ but more research is needed. For example, of more than 7,000 adults ages 50 and older receiving inpatient services for SMI, 26 percent also met criteria for an SUD.³⁴⁶ The most common SUD was for cocaine (9.5 percent).

In 2019, approximately **1.7M** Americans 50 and older were living with an SUD & a **MENTAL DISORDER.**



- For older adults with both an SUD and a mental disorder, alcohol misuse and depression are a common combination.³⁴⁷ Having these two co-occurring disorders (CODs) may lead to negative physical and behavioral health consequences. For example, in a study of adults ages 65 and older who were receiving inpatient treatment for depression, those with co-occurring alcohol misuse had higher rates of drug use, liver disease, and suicidality than older adults with depression who did not also misuse alcohol.³⁴⁸

Be sure to screen older clients who misuse substances for co-occurring mental and cognitive disorders as well. Exhibit 3.3 indicates which screening measure to use by specific disorder, plus it lists a screening instrument for elder abuse. Older adults may also be at risk for negative outcomes, including:

- Increased mortality.³⁴⁹
- Increased risk of unintentional injuries leading to emergency department service use.³⁵⁰
- Increased risk of self-harm.³⁵¹ Older adult men are at especially high risk for suicide. Older adults with CODs may also have an increased risk of suicide attempt, but this requires more research.³⁵²
- Self-medication through substance misuse.

EXHIBIT 3.3. Screening Tools for Co-Occurring Mental and Cognitive Disorders

Co-occurring conditions in general	<ul style="list-style-type: none"> • Comorbidity Alcohol Risk Evaluation Tool (CARET)
Depression	<ul style="list-style-type: none"> • Geriatric Depression Scale (GDS)—Short Form • Patient Health Questionnaire-9 (PHQ-9)
Anxiety	<ul style="list-style-type: none"> • Geriatric Anxiety Scale (GAS) • Penn State Worry Questionnaire (PSWQ)
PTSD, trauma symptoms, and elder abuse	<ul style="list-style-type: none"> • PTSD Checklist for DSM-5 • Primary Care PTSD Screen for DSM-5 • Elder Abuse Suspicion Index® (EASI®)
Cognitive impairment	<ul style="list-style-type: none"> • Mini-Cog®

CARET

You can screen for CODs using the CARET, which was developed from the short version of the Alcohol-Related Problems Survey.³⁵³ Research supports using the CARET with older adults^{354,355} to identify those at risk for alcohol misuse. The CARET asks about alcohol-related risk factors and risky behaviors—many of which you may see in older clients. Such risk factors and risky behaviors include using alcohol while also:

- Having physical conditions negatively affected by drinking (like high blood pressure and diabetes).
- Having a history of falls or accidents.
- Having memory problems.
- Having trouble sleeping.
- Feeling sad or “blue.”
- Taking medications that can be harmful when mixed with alcohol. These include arthritis and pain medications, depression medications, blood thinners, antiseizure medications, and sleep medications.
- Driving a car or other vehicle.

For more information about the items in the CARET and how to score them, please see Barnes et al., 2010.³⁵⁶

Depression Screening

Make sure to screen for depression. Depression is both a risk factor for and an outcome of substance misuse in older individuals.³⁵⁷ Approximately 4.7 percent of adults in the United States ages 50 and older have depression.³⁵⁸ MDD is commonly found in older clients who misuse substances.^{359,360}

GDS—Short Form

One of the most commonly used depression screeners for older adults is the short form of the GDS³⁶¹ (Exhibit 3.4). Clients with a GDS score of 6 or higher need further assessment and may need treatment for MDD.³⁶² Clients with a GDS score below 6 should be screened again in 1 month if symptoms of depression are still present.³⁶³ If a client’s depressive symptoms are no longer present in 1 month, give the depression screener again in 6 months.³⁶⁴

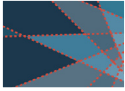


EXHIBIT 3.4. Geriatric Depression Scale (GDS)–Short Form

Client Version

Client's Name:

Date:

Instructions: Circle the best answer for how you felt over the past week.

1. Are you basically satisfied with your life?	Yes	No
2. Have you dropped many of your activities and interests?	Yes	No
3. Do you feel that your life is empty?	Yes	No
4. Do you often get bored?	Yes	No
5. Are you in good spirits most of the time?	Yes	No
6. Are you afraid that something bad is going to happen to you?	Yes	No
7. Do you feel happy most of the time?	Yes	No
8. Do you often feel helpless?	Yes	No
9. Do you prefer staying at home, rather than going out and doing new things?	Yes	No
10. Do you feel you have more problems with memory than most people?	Yes	No
11. Do you think it is wonderful to be alive now?	Yes	No
12. Do you feel pretty worthless the way you are now?	Yes	No
13. Do you feel full of energy?	Yes	No
14. Do you feel that your situation is hopeless?	Yes	No
15. Do you think that most people are better off than you are?	Yes	No

Scoring Version

Client's Name:

Date:

Scoring: Count boldface responses for a total score. A score of 0–5 is normal. A score of 6 or above suggests depression.

Instructions: Circle the best answer for how you felt over the past week.

1. Are you basically satisfied with your life?	Yes	No
2. Have you dropped many of your activities and interests?	Yes	No
3. Do you feel that your life is empty?	Yes	No
4. Do you often get bored?	Yes	No
5. Are you in good spirits most of the time?	Yes	No
6. Are you afraid that something bad is going to happen to you?	Yes	No
7. Do you feel happy most of the time?	Yes	No
8. Do you often feel helpless?	Yes	No

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9. Do you prefer staying at home, rather than going out and doing new things?	Yes	No
10. Do you feel you have more problems with memory than most people?	Yes	No
11. Do you think it is wonderful to be alive now?	Yes	No
12. Do you feel pretty worthless the way you are now?	Yes	No
13. Do you feel full of energy?	Yes	No
14. Do you feel that your situation is hopeless?	Yes	No
15. Do you think that most people are better off than you are?	Yes	No

The Client Version and Scoring Version of the GDS–Short Form were both adapted from material in the public domain.³⁶⁵

PHQ

The nine-item PHQ-9 is commonly used to screen for depression in adults of any age.³⁶⁶ It is tested and approved for use with older clients.³⁶⁷ The PHQ-9 is also useful for monitoring depression severity and treatment response in clients who already screened positive for or are diagnosed with depression. The PHQ-9 is available via <https://cde.drugabuse.gov/instrument/f226b1a0-897c-de2a-e040-bb89ad4338b9>.

A two-item version of the PHQ-9 is available (the PHQ-2) that includes only the first two questions from the PHQ-9. However, compared with the PHQ-9, the PHQ-2 has a higher likelihood of giving older adults a false positive (that is, incorrectly rating a person as depressed when they are not).³⁶⁸ To get more reliable results, you should give the full PHQ-9. If you give the PHQ-2, be sure to give the full PHQ-9 to older adults who have a total score of 3 or higher.³⁶⁹

Scoring: The total score for the PHQ-9 is derived by first summing each column (e.g., each item chosen in column “More than half the days” = 2), then summing the column totals. Total scores range from 0 to 27 and indicate the following levels of depression severity:

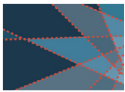
0–4: None-minimal
 5–9: Mild depression
 10–14: Moderate depression
 15–19: Moderately severe depression
 20–27: Severe depression

In addition to the total score, review responses to Question #9 (suicidality) and the unnumbered question below it (the effect of symptoms on the client’s daily functioning) when determining whether to initiate or refer for further assessment and treatment.^{370,371,372}

Screening for Anxiety

About 10 to 11 percent of older adults have had an anxiety disorder in the past year.^{373,374} About 15 percent have had an anxiety disorder in their lifetime.³⁷⁵ Older women may be especially at risk for anxiety. The number of women ages 55 and older with any anxiety disorder in the past year has been estimated to be almost double that of older men (about 14 percent versus nearly 8 percent).³⁷⁶

Anxiety is underdiagnosed in the older adult population.³⁷⁷ Providers may view older clients’ worries and concerns as a normal part of aging.³⁷⁸ Older adults’ symptoms of anxiety can also be mistaken for physical conditions common in older age, as well as depression.³⁷⁹



Yet different types of anxiety disorders can and do occur in older people. Some of these include:

- **Generalized anxiety disorder (GAD), panic disorder, and social phobia.**³⁸⁰ In the National Comorbidity Survey Replication, the 12-month prevalence of GAD in people ages 65 and older was 1.2 percent.³⁸¹ In the same study, 0.7 percent of adults ages 65 and older had past-year panic disorder, and 2.7 percent had past-year social phobia.
- **PTSD.** Estimates of past-year PTSD prevalence for those 65 or older range from 0.4 percent to 2.6 percent.^{382,383}

Symptoms of anxiety that are present but do not meet full criteria for an anxiety disorder are more common than full anxiety disorders. **As many as half, or possibly slightly more, of older adults in the community and in treatment settings may have anxiety symptoms.**³⁸⁴

It is not unusual for older people with anxiety to misuse substances, especially alcohol and tobacco:

- In the National Epidemiologic Survey on Alcohol and Related Conditions, adults 65 and older with any anxiety disorder in their lifetime had a 1.5 times greater chance of having a lifetime AUD, when compared with adults 65 and older without anxiety disorders.³⁸⁵ They also had a 1.6 times greater chance of having a lifetime tobacco use disorder.³⁸⁶

- Among older people assessed for treatment for alcohol misuse,³⁸⁷ the most commonly reported reason for using alcohol among women (24 percent) was “to reduce tension or anxiety.” This was also the second-most-common reason reported by men (20 percent).
- Adults ages 55 and older with GAD in the past year were 2.2 times more likely to have had an SUD in the past year.³⁸⁸ Adults ages 50 to 64 who had an anxiety disorder in the past year were 1.7 times more likely to have smoked cigarettes in the past year.³⁸⁹

A review of anxiety assessment tools created for or approved for use with older people³⁹⁰ found the PSWQ and the Geriatric Mental Status Examination are useful and strongly supported by scientific evidence. The Geriatric Mental Status Examination is a somewhat lengthy semistructured interview, not a brief screening tool. For that reason, it is not included here. **Another valid and reliable self-report anxiety scale designed specifically for older people is the GAS (Exhibit 3.5).**³⁹¹ The original GAS has 30 items. A short form of only 10 items was developed and, like the full measure, was found to be valid for use in older people.³⁹²

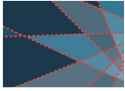
Higher scores on the GAS indicate higher anxiety. More research in larger clinical samples is needed to determine the optimal cutoff score, although in the 30-item scale, a cutoff of 16 may be clinically useful.³⁹³

EXHIBIT 3.5. Geriatric Anxiety Scale (GAS)

Below is a list of common symptoms of anxiety or stress. Please read each item in the list carefully. Indicate how often you have experienced each symptom during the **PAST WEEK, INCLUDING TODAY**, by checking under the corresponding answer.

	Not at all (0)	Sometimes (1)	Most of the time (2)	All of the time (3)
1. My heart raced or beat strongly.				
2. My breath was short.				
3. I had an upset stomach.				
4. I felt like things were not real or like I was outside of myself.				
5. I felt like I was losing control.				
6. I was afraid of being judged by others.				
7. I was afraid of being humiliated or embarrassed.				
8. I had difficulty falling asleep.				
9. I had difficulty staying asleep.				
10. I was irritable.				
11. I had outbursts of anger.				
12. I had difficulty concentrating.				
13. I was easily startled or upset.				
14. I was less interested in doing something I typically enjoy.				
15. I felt detached or isolated from others.				
16. I felt like I was in a daze.				
17. I had a hard time sitting still.				
18. I worried too much.				
19. I could not control my worry.				
20. I felt restless, keyed up, or on edge.				
21. I felt tired.				
22. My muscles were tense.				
23. I had back pain, neck pain, or muscle cramps.				
24. I felt like I had no control over my life.				

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	Not at all (0)	Sometimes (1)	Most of the time (2)	All of the time (3)
25. I felt like something terrible was going to happen to me.				
26. I was concerned about my finances.				
27. I was concerned about my health.				
28. I was concerned about my children.				
29. I was afraid of dying.				
30. I was afraid of becoming a burden to my family or children.				

GAS Scoring Instructions

Items 1 through 25 are scorable items. Each item ranges from 0 to 3. Each item loads on only one scale. Items 26 through 30 are used to help clinicians identify areas of concern for the respondent. They are not used to calculate the total score of the GAS or any subscale.

Total Score = sum of items 1 through 25.

Somatic subscale (9 items) = sum of items 1, 2, 3, 8, 9, 17, 21, 22, 23

Cognitive subscale (8 items) = sum of items 4, 5, 12, 16, 18, 19, 24, 25

Affective subscale (8 items) = sum of items 6, 7, 10, 11, 13, 14, 15, 20

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The PSWQ³⁹⁵ is a self-report instrument with 16 items, each rated on a 5-point scale. Items 1, 3, 8, 10, and 11 are reverse scored as follows:

- Very typical of me = 1 (circled 5 on the sheet)
- Circled 4 on the sheet = 2
- Circled 3 on the sheet = 3
- Circled 2 on the sheet = 4
- Not at all typical of me = 5 (circled 1 on the sheet)

The remaining items are scored regularly. The item scores are added to produce a total score ranging from 16 to 80, with higher scores reflecting more worry. **A score of 50 or higher by an older person could mean significant worries are present**, but research on cutoff scores in older people is too limited to know for certain.³⁹⁶ Do not assume that an older client who scores below 50 does not have anxiety. The PSWQ is available in the Chapter 3 Appendix.

Screening for PTSD, Trauma Symptoms, and Abuse

People with PTSD are at high risk for substance misuse.³⁹⁷ People with PTSD may use substances to help themselves cope and feel better. Even if a person does not meet criteria for PTSD, experiencing a traumatic event at any point in one's life raises the risk for substance misuse.^{398,399} As with any other clients, explore whether older clients have a history of trauma.

About 52 percent of people 50 and older have had at least one adverse childhood experience,⁴⁰⁰ such as sexual abuse, physical abuse, neglect, or extremely stressful family events including:

- Seeing the abuse of a family member.
- Living in the home with someone who misuses substances or has a mental disorder.
- Experiencing the death of a parent or abandonment by one's parents.

- Having a household member in the criminal justice system.

PTSD in older adults is not very common.

Past-year PTSD occurs in only about 0.4 percent to 2.6 percent of people ages 65 and older.^{401,402} Many people with trauma do not meet criteria for PTSD but do meet criteria for depression.⁴⁰³ **Thus, depression screening is important in older clients who misuse substances.**

Trauma in older clients can include being a current victim of elder abuse. According to CDC, 1 in 10 adults (ages 60 or older) who live at home is a victim of elder abuse each year.⁴⁰⁴ Elder abuse can manifest as emotional (or mental) abuse, financial abuse (or exploitation), physical abuse, sexual abuse, and neglect.⁴⁰⁵ Of women over age 65, 20 to 30 percent have been victims of intimate partner violence.⁴⁰⁶ Older adults who experience abuse are more likely to:⁴⁰⁷

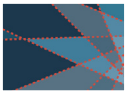
- Have depression or anxiety.
- Have thoughts of suicide.
- Attempt suicide.
- Need emergency department care.
- Be hospitalized.
- Die prematurely.

Some research shows that older adults from minority ethnic or racial groups may be more likely to experience abuse.⁴⁰⁸ The most recent nationally representative study of elder abuse found that lack of social support is a primary risk factor for experiencing elder abuse and for having negative outcomes following such abuse.⁴⁰⁹ Cognitive disorders are a major risk factor for experiencing abuse. Older adults with dementia are almost five times more likely to be victims of abuse as older people without dementia.⁴¹⁰

Ask all older clients with ongoing or past substance misuse about their history of trauma, including trauma in childhood and current trauma. Be sure to ask about any current abuse, including intimate partner abuse. Use brief screening measures to further explore these areas. Screening for trauma and abuse in older clients is important, as older adults with PTSD may have different or milder symptoms than younger clients. PTSD can thus be harder to recognize in older people.⁴¹¹

Trauma is a sensitive topic for many clients. You need to know not just what to ask but how to ask it. Otherwise, clients might “shut down” or feel uncomfortable sharing private details with you. Some tips to help you assess trauma fully but in a gentle, sensitive manner include the following:⁴¹²

- **Remind the client you are there as a support.** Explain what will take place during and after the screening and assessment so that the individual knows what to expect.
- **Use screening and assessment tools that have been well researched and approved for use with older adults.**
- **Remember that trauma can come in many forms.** Use a checklist or question list to make sure you cover all possible traumas and not just ones that are commonly thought of (like physical and sexual abuse). You can find more information about Adverse Childhood Experiences (ACEs) on the CDC’s website (www.cdc.gov/violenceprevention/childabuseandneglect/acestudy/index.html).
- **Tell clients that they can answer whichever questions they wish, however they wish.** If they choose to only partly answer a question, that’s okay. If they choose not to answer a question at all, that’s also fine.
- **Remind them that they are safe.** Sometimes talking about a trauma can feel scary, as if the traumatic event is happening again. You don’t want clients to feel that talking about their trauma is dangerous. This could lead them to avoid talking about it altogether, and that is not helpful.
- **Do not ask clients to “relive” their trauma by describing it in detail.** Let your clients answer questions about their trauma in the ways that are most comfortable to them. There’s no “right or wrong way” for them to talk about their experiences.
- **Ask how the client’s trauma symptoms affect functioning.** This includes ability to complete daily activities, engage in self-care, and maintain intimate relationships and a healthy social life.
- Screen clients with histories of trauma for CODs and suicide risk.
- Some people naturally feel more comfortable sharing information in writing than verbally.



Have paper-and-pencil or computerized self-report trauma measures on hand for clients who would rather not take part in a clinical interview.

- **Share resources and information with clients** as needed to keep them safe and feeling supported.
- **End positively.** After assessment, ensure that the client feels safe and ready to leave the session.

PTSD Checklist for DSM-5

The PTSD Checklist for DSM-5 (PCL-5; Exhibit 3.6) is an updated version of the widely used and researched PTSD Checklist (PCL), which was based on DSM-IV criteria. Not much research has yet been conducted on the use of the PCL-5 with older adults. The PCL-5 has been used to screen for PTSD in some studies of older veterans,^{413,414,415} but these studies were not designed to look at the validity of the PCL-5 in aging populations. More research is needed in this area.

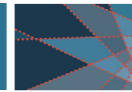
The optimal PCL-5 cutoff score in older adults is unclear. One study of Vietnam veterans (thus, mostly older men) found a PCL-5 score of 37 made the best cutoff for PTSD screening.⁴¹⁶ The Department of Veterans Affairs (VA) instructions on the PCL-5 (www.ptsd.va.gov/professional/assessment/adult-sr/ptsd-checklist.asp) note a cutoff score of 33 as “reasonable” to use until further research is published on the best cutoff scores in different groups of people (such as veterans versus civilians).⁴¹⁷ The VA warns that cutoff scores from the original PCL and those for the PCL-5 are neither equal nor interchangeable given that the PCL-5 contains changes in rating scales and number of items. **You should not use PCL cutoff scores when interpreting scores from the PCL-5.**

EXHIBIT 3.6. PTSD Checklist for DSM-5 (PCL-5)

Instructions: Below is a list of problems that people sometimes have in response to a very stressful experience. Please read each problem carefully and then circle one of the numbers to the right to indicate how much you have been bothered by that problem in the past month.

In the past month, how much were you bothered by:	Not at all	A little bit	Moderately	Quite a bit	Extremely
1. Repeated, disturbing, and unwanted memories of the stressful experience?	0	1	2	3	4
2. Repeated, disturbing dreams of the stressful experience?	0	1	2	3	4
3. Suddenly feeling or acting as if the stressful experience were actually happening again (as if you were actually back there reliving it)?	0	1	2	3	4
4. Feeling very upset when something reminded you of the stressful experience?	0	1	2	3	4
5. Having strong physical reactions when something reminded you of the stressful experience (for example, heart pounding, trouble breathing, sweating)?	0	1	2	3	4

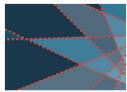
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In the past month, how much were you bothered by:	Not at all	A little bit	Moderately	Quite a bit	Extremely
6. Avoiding memories, thoughts, or feelings related to the stressful experience?	0	1	2	3	4
7. Avoiding external reminders of the stressful experience (for example, people, places, conversations, activities, objects, or situations)?	0	1	2	3	4
8. Trouble remembering important parts of the stressful experience?	0	1	2	3	4
9. Having strong negative beliefs about yourself, other people, or the world (for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)?	0	1	2	3	4
10. Blaming yourself or someone else for the stressful experience or what happened after it?	0	1	2	3	4
11. Having strong negative feelings such as fear, horror, anger, guilt, or shame?	0	1	2	3	4
12. Loss of interest in activities that you used to enjoy?	0	1	2	3	4
13. Feeling distant or cut off from other people?	0	1	2	3	4
14. Trouble experiencing positive feelings (for example, being unable to feel happiness or have loving feelings for people close to you)?	0	1	2	3	4
15. Irritable behavior, angry outbursts, or acting aggressively?	0	1	2	3	4

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In the past month, how much were you bothered by:	Not at all	A little bit	Moderately	Quite a bit	Extremely
16. Taking too many risks or doing things that could cause you harm?	0	1	2	3	4
17. Being “superalert” or watchful or on guard?	0	1	2	3	4
18. Feeling jumpy or easily startled?	0	1	2	3	4
19. Having difficulty concentrating?	0	1	2	3	4
20. Trouble falling or staying asleep?	0	1	2	3	4

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Primary Care PTSD Screen for DSM-5

The Primary Care PTSD Screen for DSM-5⁴¹⁹ (PC-PTSD-5) is a five-item questionnaire that identifies clients likely to have PTSD. It was approved for use in a sample of older veterans (mostly male; mean age 63 years).⁴²⁰ All questions are yes/no. A score of 3 or more “yes” responses is considered positive.⁴²¹ More information on using this tool is available online (www.ptsd.va.gov/professional/assessment/documents/pc-ptsd5-screen.pdf). The PC-PTSD-5 is available in the Chapter 3 Appendix.

Elder Abuse Suspicion Index®

The Elder Abuse Suspicion Index^{®422} is a six-item yes/no questionnaire. You should ask the client Questions 1 through 5. You can answer Question 6 yourself. Questions apply to the last 12 months. A “yes” response on one or more questions (other than on Question 1) is considered a positive screen. This measure appears in the Chapter 3 Appendix.

Screening for Co-Occurring Cognitive Disorders

You should also screen older clients who misuse substances for cognitive impairment, which includes dementia and mild cognitive impairment (MCI). **Dementia** is a brain disorder affecting

mental ability and personality that gets worse over time. Several types of dementia exist, such as Alzheimer’s (the most common form) and Parkinson’s dementia. People with dementia have difficulties in at least one area of thinking, such as memory, learning, language, or attention. These difficulties make it hard for people to live their everyday lives without help from others (e.g., needing help getting dressed, bathing, feeding themselves, or managing their money). Current research suggests almost 9 percent of Americans ages 65 and older have dementia.⁴²³ That includes over 3 percent of people ages 65 to 74, roughly 10.5 percent of people ages 75 to 84, and almost 30 percent of people ages 85 and older.⁴²⁴

MCI is a milder form of cognitive impairment that often represents early brain changes that may precede and lead to dementia. In MCI, deficits in thinking from a previous level of performance are present but are not severe enough for a person to need help from others in their everyday life. A person with MCI is at increased risk of developing Alzheimer’s or another type of dementia. About 10 percent to 20 percent of adults in the United States ages 65 and older have MCI, with the likelihood increasing with age.^{425,426,427} (Chapter 6 of this TIP provides more information about cognitive disorders and older adults who misuse substances.)

Substance misuse, especially heavy alcohol use, can negatively affect thinking. Keep in mind that:

- Heavy alcohol use can harm the brain, heart, liver, and other organs.^{428,429}
- Alcohol's negative effects on the brain can lead to memory problems, difficulty learning new information, and difficulty thinking quickly.^{430,431,432}
- Heavy alcohol use can also cause brain cells and tissues to shrink or no longer work properly.⁴³³
- In some people, even moderate alcohol use can harm the brain.⁴³⁴
- Heavy drinking may do more harm to older adults' cognitive abilities than those of younger adults.⁴³⁵

Less research has been done on how substances other than alcohol can affect one's chances of having a cognitive disorder like dementia or MCI. However, **the long-term use of benzodiazepines,^{436,437,438} cannabis,^{439,440,441} cocaine,⁴⁴² and tobacco does seem to carry a somewhat greater risk of cognitive problems.⁴⁴³**

Mini-Cog®

The Mini-Cog® is a brief screening tool that was created to detect dementia in older adults. It takes about 3 minutes to complete and involves a verbal memory task and a clock drawing task. The Alzheimer's Association endorses using the Mini-Cog® in primary care settings to screen for cognitive impairment, and the National Institute on Aging lists it as an instrument to consider using for this purpose.^{444,445} Several reviews have found the Mini-Cog® to have acceptable-to-good test characteristics (e.g., sensitivity, specificity, negative predictive value), although research suggests that it is better at detecting dementia than MCI.^{446,447,448}

The Mini-Cog® and its administration and scoring instructions are freely available to individual clinicians at <https://mini-cog.com/mini-cog-instrument/standardized-mini-cog-instrument>. Two brief screening tools for cognitive impairment that have been more widely administered—the Montreal Cognitive Assessment (which was created to screen for MCI) and the Mini-Mental State Examination—now have costs associated with their use.^{449,450}

Communicating Screening Results

Knowing what to do after screening is as important as knowing why and how to screen in the first place. Whether negative or positive, you should **inform all clients of their screening results**. Read further to learn the specific steps to take next, which will differ based on the client's screening results.

Negative Results

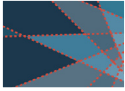
No formal intervention is needed for people who screen negative. Instead:

- **Acknowledge clients who are substance free.** ("I see that it's important to you not to smoke.")
- **Offer positive comments about the benefits of drug- and alcohol-free living.** ("You know, people who don't smoke generally live longer, healthier lives than people who do.")
- **Reinforce attitudes, behaviors, and strategies that promote health.** Think about asking whether their lack of substance use is new or lifelong, or whether it is because they are in recovery. ("Not drinking is a healthy decision. What made you decide not to drink?")

For older adults who screen negative or at low risk for substance misuse, be sure to:

- Use positive language to urge them to continue using substances appropriately.
- Give brief education, such as reminding them of low-risk alcohol intake levels for older adults.
- Continue monitoring them for future signs and symptoms of possible at-risk substance use.

Even if a screener is negative, the TIP consensus panel recommends that you occasionally rescreen clients. Why is that necessary? Because substance use can change over an individual's lifetime. Substance use patterns can also change with life events, cognitive functioning, and mental health status.



No clear scientific data indicate exactly how often you should rescreen clients. The TIP consensus panel recommends that you use your clinical judgment to determine how often to rescreen. You might consider screening more often (at least once a year) if the client has repeatedly requested prescription drugs or has certain conditions, such as:

- Physical conditions that are often alcohol or drug related (e.g., high blood pressure, insomnia).
- Diabetes or ulcers unresponsive to treatment.
- Staph infection on face, arms, or legs.
- Repeated fractures, lacerations, or burns.
- Depression.
- Unexplained weight loss.
- Frequent falls.
- Repeated trauma suggesting domestic violence.
- Sexually transmitted diseases.

When doing an SUD screen, if the depression screener is negative but the client has some symptoms of depression, you will want to give another depression screen in 1 month. Symptoms to look for include low mood, difficulty making decisions, loss of interest in pleasurable activities, and feelings of hopelessness. You should continue to monitor the client's symptoms over time. You may want to give another depression screen earlier if the client reports worsening symptoms or if the client seems to be feeling worse. **If the depression screen is negative and the client has few or no symptoms of depression, you can continue screening on a yearly basis.** If the client reports new symptoms or you suspect the person may be feeling depressed at any time, you should give a depression screener again.

When doing an SUD screen, if trauma or elder abuse screeners are negative, continue with routine clinical care. Rescreen any time you suspect that trauma or abuse has occurred. For instance, if a client reports disagreements with her husband and has visible bruises, screen for possible abuse.

You can also give a substance-related, depression, or trauma screener again if the client experiences major changes that could lead to substance misuse, depression, anxiety, or PTSD. Such changes include the death of someone significant to the client, a transition to an assisted living residence or nursing home, or retirement.

Positive Results

For clients who screen positive for potential substance misuse, three possible approaches exist. These are based on the severity of the problem and possible risk of having substance misuse. (None of the three approaches listed below is appropriate for an intoxicated client, who may need an immediate and specific response [e.g., referral to detoxification].) The three approaches are:

- **Immediately give a brief assessment** during the same visit in which you gave the screening measure. (See the section "Conducting Brief Assessments and Interventions" below.)
- **Give a full assessment** if the screening results are unclear. You may need to schedule another visit for this longer assessment.
- **Refer the client to another provider for assessment.** Refer high-risk clients to a program where specialized SUD treatment services are available, if possible.

If a cognitive screener is positive, you should refer the client for further testing by a behavioral health service provider with special training in diagnosing clients with dementia and MCI. Making such diagnoses requires additional, indepth cognitive testing. Do not give a diagnosis of dementia or MCI based solely on a positive cognitive screen.

If a depression, anxiety, PTSD, or trauma screener is positive, give a full assessment using DSM-5 diagnostic criteria to determine whether a disorder is present (or refer the client for further evaluation if you do not have the training and credentials to make a mental disorder diagnosis).

This may mean giving a full diagnostic interview, perhaps at another appointment. Even if full diagnostic criteria are not met, the client may still benefit from treatment if symptoms are upsetting or interfere with daily living.

If an elder abuse screener is positive, follow your state’s laws on reporting suspected abuse. Unless you work in private practice, you first need to contact your immediate supervisor to ensure that you are following program procedures and abiding by state laws. You may need to consult with social services or Adult Protective Services on next steps. The Department of Justice provides a list of online resources to help you learn your state’s laws about reporting abuse and involving Adult Protective Services (www.justice.gov/elderjustice/elder-justice-statutes-0). The National Center on Elder Abuse links to state-specific reporting numbers and other agencies (<https://ncea.acl.gov/Resources/State.aspx>). Make sure you are familiar with these laws and resources before giving abuse screeners so that you can act right away if a screener is positive.

Present the results of positive screens to clients in a gentle manner. For example, you might say, “After reviewing your answers on the screening questionnaire, there are some things I’d like to follow up on with you,” or, “Your answers are similar to the answers of people who may be having a problem with alcohol.”

Conducting Brief Assessments and Interventions

Positive screens for substance misuse require follow-up, but next steps may not be immediately clear. Decisions about follow-up care depend on how much time and effort you can expend, how much training and experience you have in drug and alcohol counseling, and your program’s treatment abilities. Also essential are the client’s agreement, engagement level, and preferences.

Starting Off on the Right Foot

A successful assessment starts by creating a welcoming environment. This is key to helping older clients “open up” and feel safe talking about substance misuse. You can do this by keeping a gentle, respectful, and empathetic attitude. Many clients who misuse substances feel uncomfortable talking about their substance use in medical settings. A friendly, nonjudgmental atmosphere can put clients at ease and help them share information they may find embarrassing, like feeling depressed or being abused.⁴⁵¹ Using motivational interviewing approaches, such as asking open-ended questions, is more helpful than asking basic yes/no questions.⁴⁵² (See the Substance Abuse and Mental Health Services Administration’s [SAMHSA] update of TIP 35, *Enhancing Motivation for Change in Substance Use Disorder Treatment* [<https://store.samhsa.gov/product/TIP-35-Enhancing-Motivation-for-Change-in-Substance-Use-Disorder-Treatment/PEP19-02-01-003>]).

What is motivational interviewing (MI)? Per SAMHSA, it is a clinical approach to helping clients make positive changes in their behavior. MI involves techniques like showing concern and empathy, avoiding arguing, and supporting a client’s self-efficacy (a person’s belief that he or she can successfully make a change).

Keep in mind that almost all clients will have mixed feelings about their substance use. They will find some aspects of it pleasant and beneficial but other aspects difficult, painful, or harmful. You can help clients discover their own reasons for wanting to change by talking about these mixed feelings and pointing out problem areas.

SAMHSA’s TIP 34, *Brief Interventions and Brief Therapies for Substance Abuse*, offers more guidance on how to make assessment and interviews successful.⁴⁵³



Looking for a simple way to help clients “open up”? Avoid asking yes/no questions. Open-ended questions are more thought-provoking and help clients share their own experiences in a more meaningful way. Start by asking broad questions about a client’s health in general, such as:

- “How would you rate your health overall?”
- “Compared with other people your age, how would you say you are doing?”
- “What health problems do you have?”

Next, move into more specific questions about the client’s substance misuse. Try asking questions like:

- “What concerns do you have about your alcohol use?”
- “In what ways might your life be different were you not using tobacco?”
- “How has using opioids affected your relationships?”

Questions that can be answered with a simple “yes” or “no” can seem harsh or judgmental. Older clients might already feel ashamed and uncomfortable talking about their substance use. Closed-ended questions could make those feelings even worse and cause clients to “shut down.” On the other hand, open-ended questions can help clients become aware of and express their own experiences and motivations related to substance use.

Brief Assessments

If a client’s screening results show mild substance misuse, conduct a brief assessment to get more information. Assessment questions should cover:

- The severity of substance use (including what, how often, and how much the client uses).
- The types of problems connected with the client’s use.
- The frequency of problems that occur with the client’s use.
- Other special physical and mental factors (e.g., whether a mental or physical disorder is present that could be making the person’s substance-related symptoms worse).

If the client’s responses suggest an SUD diagnosis per DSM-5 criteria, you should conduct or provide a referral for an indepth assessment. However, you can give a brief outpatient therapeutic intervention if:

- Only mild or mild-to-moderate substance misuse is present.
- The client appears to be at risk for harm because of current substance use.
- Co-occurring illnesses or conditions may be made worse by continuing to drink or use drugs.
- The client declines referral for further assessment or treatment.

Brief Interventions: SBIRT

SBIRT is an approach to providing brief interventions after screening, referrals for further assessment, or treatment. SBIRT approaches are focused on getting clients into treatment early. They include:

- **Screening** for possible substance misuse and level of risk.
- **Offering a brief outpatient intervention** to help clients understand the need to change their substance misuse and help them increase their desire to change.
- **Referrals** to SUD treatment programs or mental health services for clients who need more indepth assessment or intervention.

Behavioral health service and healthcare providers can easily **incorporate brief interventions into standard practices**. Brief interventions:

- Give you the chance to:
 - Explain screening results to clients.
 - Provide information about low-risk substance use.
 - Give advice about changing substance misuse habits.
 - Assess clients’ desire for change.
 - Work with clients to set goals and strategies for change.
 - Figure out how best to make sure clients are sticking with their treatment plan.

- Are usually only 10 to 15 minutes long and include a limited number of sessions.
- May require at least one follow-up visit. However, even more follow-up sessions may be needed depending on the setting, the severity of the substance misuse, and clients' responses.
- Are usually inexpensive and quick to conduct.

Most older adults at risk for substance misuse do not need formal specialized SUD treatment.

However, many clients can benefit from education to prevent problems before they occur. They can also benefit from SBIRT techniques. For instance, SBIRT that involves basic education as an intervention has been shown to help reduce older adults' risky alcohol use.^{454,455} Educate clients on risky alcohol use as a prevention measure and an intervention. Boston University School of Public Health provides helpful information and resources (e.g., demonstration videos) on screening and brief intervention techniques successfully used in primary care and emergency department settings (www.bu.edu/bniart/sbirt-in-health-care/sbirt-brief-negotiated-interview-bni/).

Why do your clients want to change their substance misuse? Knowing the answer to this question is more useful than just knowing whether clients are ready to change. Helping clients explore their reasons for wanting to change their substance use can help them feel more positive and confident about making this change. It also helps better support them during assessment and treatment. It is okay if the reasons for change are initially attributable to outside forces rather than the clients' own desires. Clients pressured into treatment—such as through parole and probation or drug courts—are as or sometimes more likely to succeed in treatment as clients who enter on their own.⁴⁵⁶

SBIRT services must meet the special age-related needs of older adults to give them the greatest chance for success (Exhibit 3.7). You can make your SBIRT services age sensitive by:

- **Using supportive language** in your discussions so that older clients do not feel shame or fear.
- **Using clear, basic terms** with older clients rather than confusing terms or medical language.
- **Sharing information that is specific to older clients**, such as guidelines about low-risk levels of substance use for older adults or physical effects of substance misuse.
- **Including strategies and materials that are culturally sensitive** to clients and to the unique issues that older adults face. For example, your older adult clients may be:
 - Worrying about not being able to live independently, without help from others.
 - Coping with grief (over loss of a partner, spouse, child, or another significant person).
 - Adapting to major life changes, like retiring or moving into an assisted living residence.
- **Thinking about the role of chronic physical conditions in older clients' misuse of substances** (e.g., use of substances to manage chronic pain). Such conditions can also affect symptoms of substance misuse and treatment response.
- **Using tailored screening and assessment measures** that were made specifically for older adults or are approved for use with them.
- **Giving interventions that meet older clients' needs.** For instance, if possible, in-home treatment is helpful if clients cannot travel to your program.
- **Keeping referral information on hand** about local providers who specialize in addiction treatment and are skilled at working with older adults who misuse substances.

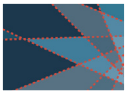


EXHIBIT 3.7. Successfully Applying SBIRT Principles to Older Adults

The Florida Brief Intervention and Treatment for Elders (BRITE) pilot project⁴⁵⁷ was funded by the Center for Substance Abuse Treatment and modeled on SBIRT. In this program, older adults who screened as needing a brief SUD intervention received:

- **Education** to help reduce substance misuse, develop healthier habits, and improve quality of life.
- **MI** to increase their desire to change substance misuse-related behaviors.
- **Age-appropriate information** designed to address high-risk situations, coping with urges to use substances, and preventing return to substance misuse.

Results from the program were positive.⁴⁵⁸ Specific outcomes included the following:⁴⁵⁹

- Clients who completed the program had lower SMAST-G scores.
- At the end of the study, nearly 30 percent of clients in the BRITE program had fewer flags in their medical chart for prescription medication misuse.
- People in the BRITE program had large decreases in depression (measured by the GDS) and suicide risk scores.
- The number of older adults getting treatment in the program was three times greater than the number who were getting SUD services before BRITE began.

RESOURCE ALERT: DESIGNING AND IMPLEMENTING SBIRT PROGRAMS FOR OLDER ADULTS

SAMHSA's *A Guide to Preventing Older Adult Alcohol and Psychoactive Medication Misuse/Abuse: Screening and Brief Interventions* is a manual to assist addiction treatment providers and administrators in designing, implementing, and delivering screening and brief intervention programs to prevent substance misuse in older adults. It is available online (www.ncoa.org/wp-content/uploads/SBIRT-Older-Adult-Manual-Final.pdf). SAMHSA has other resources to help you integrate SBIRT into your program (www.samhsa.gov/sbirt/resources).

The National Council on Aging also offers an instruction manual and workbook for effective screening and brief intervention strategies for risky alcohol use in older adults (www.ncoa.org/wp-content/uploads/BI_OlderAdults_ImplementationManual.pdf).

Conducting Full Assessments for Substance Misuse

Conduct a full assessment for any client whose screening suggests moderate-to-severe substance misuse. Full assessments gather not just substance-related information, but information about overall functioning and health (Exhibit 3.8). This information will help you differentiate among substance misuse, CODs, physical conditions common in older populations, and symptoms of normal aging. Common physical conditions and symptoms of normal aging that can be confused for substance misuse include low energy, memory changes, sleep problems, and decreased appetite.

EXHIBIT 3.8. Key Objectives of a Full Assessment for Substance Misuse

Key objectives of giving a full assessment for substance misuse can include:

- Getting older clients' substance use history (including prescription and OTC medications).
- Checking clients for CODs that can affect substance misuse, such as depression, anxiety, and PTSD.
- Checking clients for other trauma or abuse.
- Learning older clients' physical conditions and physical and medication history. This is especially important for physical conditions that can lead to or result from substance misuse, like sleep problems and pain.
- Asking about social supports available to older clients who misuse substances.
- Referring clients with cognitive problems for a full cognitive assessment by a neuropsychologist or neuropsychiatrist to see whether dementia, MCI, or delirium is present.
- Understanding clients' unique substance misuse. This means asking them about:
 - When and with whom they misuse substances.
 - Why they misuse substances.
 - How misusing substances fits into their life.
 - How they feel and what they believe about their misuse of substances.

Full assessments often involve several members of the care team, depending on the setting and available resources of your program. Which care team members contribute to the full assessment depends on the qualifications and level of expertise needed to address the client's problems. For instance, the assessment may start with a certified drug and alcohol counselor or other licensed provider taking a complete psychosocial history. Other licensed providers may need to complete a psychological evaluation (e.g., if the intake interview is given by someone not licensed to diagnose mental disorders) and look for withdrawal indicators or educate the client on the need for

medical withdrawal. A medical staff member may take a medical history and perform a physical exam. Nurses or occupational therapists, rather than behavioral health service providers, usually give assessments of ADLs and fall risk. If your program does not have any medical staff members, you should refer clients elsewhere for this part of the assessment. A physician, nurse, or pharmacist may be consulted to determine risk for medication misuse, whether accidental or intentional.

Determining risk for medication misuse involves reviewing the client's:

- Current prescriptions and OTC medications.
- Management of these medications.
- Ability to obtain prescriptions (referring to cost as well as accessibility).
- Potential adverse reactions to medications.

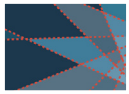
Full assessments help the treatment team:

- **Make the right diagnosis** (whether it be an SUD, a mental disorder, or a cognitive disorder).
- **Learn the severity** of the substance misuse.
- **Guide treatment planning**, including giving clients the right level of care in the right setting.
- Decide whether medical conditions are present that need to be addressed during treatment.
- Decide whether other conditions are present that need to be addressed during treatment.

The Assessment Process

A complete assessment has several parts. These include:

- Full mental health, medical, family, vocational, social, sexual, financial, legal, substance use, and SUD treatment histories.
- A health history and physical exam for common co-occurring physical conditions that affect mental health as well as physical conditions that suggest the client has substance misuse (e.g., sleep problems, chronic pain). This part of the assessment also sometimes includes biological screening measures, like urine screens (for benzodiazepines and opiates), breath alcohol testing (i.e., breathalyzer), and laboratory tests. Medical professionals should also check



the Prescription Drug Monitoring Program for additional information about clients' prescribed medications.

- Further assessment for CODs. Sometimes referral to an outside provider (e.g., licensed psychologist, clinical social worker) is needed, depending on the expertise of the staff members in your program.
- Assessment of skills used in everyday living, like dressing, bathing, shopping, and managing money.
- Assessment of the client's fall risk. (For example, see the CDC's fall prevention program, "Stopping Elderly Accidents, Deaths, and Injuries," at www.cdc.gov/steady/.)
- Assessment of the client's basic needs (e.g., housing, nutrition), support network, and strengths/resources.

The most important parts of your full assessment are gathering information about the client's substance use, mental health, physical health, and SUD treatment histories, as well as a listing of prescribed and OTC medications. It may take multiple visits to complete the assessment. Clients will feel safe sharing detailed information as their trust in you builds.

The following sections describe some of the most common parts of a full assessment, targeting only those parts that are most appropriate for older clients who misuse substances. The sections do not cover questions about a client's recreational, military, occupational, or avocational/retirement history.

The section on health history and the physical exam discusses disordered sleep and pain because these are common physical conditions seen in older people who misuse substances. But other health and physical assessments may be needed beyond what is listed in that section.

Make sure you have the required training and qualifications before assessing for or diagnosing SUDs. If no providers in your program have the necessary licenses and qualifications to assess for and diagnose mental disorders, make referrals as necessary to providers who can do so.

Health History and Physical Exam

Taking a complete physical history of clients is very important. Asking about clients' physical history can help you learn about:

- **The medical effects of their substance use** (e.g., soft tissue infection, hepatitis B or C, HIV infection) that may need treatment.
- **Consequences of substance misuse** that might get clients to change (e.g., elevated blood pressure, worsening acid reflux symptoms, increased risk of falls).
- **Physical health issues** (e.g., severe liver disease) that affect whether medications can be given for certain SUDs, such as opioid use disorder.
- Possible drug–drug interactions.

Sleep problems

Sleep quality is closely linked to substance misuse in adults in general. For instance:

- Alcohol misuse and withdrawal can lead to many types of sleep problems. These include:^{460,461}
 - Increased awakening during the night.
 - Insomnia.
 - Excessive daytime sleepiness.
 - Less total sleep time.
 - Worsening of sleep apnea and other breathing-related sleep conditions.
- Adults ages 50 and older who binge drink are at an increased risk of insomnia compared with adults in this age group who do not binge drink.⁴⁶²
- Compared with people who have never smoked cigarettes, people who smoke report having worse sleep quality, taking longer to fall asleep, sleeping less than 6 hours, and having disturbed sleep.⁴⁶³
- Cocaine use is linked to taking longer to fall asleep and having decreased total sleep time.⁴⁶⁴
- Chronic opioid use is associated with an increased risk of central sleep apnea and other breathing-related sleep problems.⁴⁶⁵

RESOURCE ALERT: SAMHSA GUIDANCE ON TREATING SLEEP DISORDERS IN CLIENTS WITH SUDS

SAMHSA's *Treating Sleep Problems of People in Recovery From Substance Use Disorders* offers tips on how to manage clients who have SUDs and sleep problems.⁴⁶⁶ It is available online (<https://store.samhsa.gov/product/Treating-Sleep-Problems-of-People-in-Recovery-From-Substance-Use-Disorders/sma14-4859>).

Sleep is an important part of clients' physical history. Sleeping less and waking earlier are normal parts of aging. But it is abnormal for older clients to be very tired in the day or not sleep through the night. These problems can increase risk of negative events like falls and even death.^{467,468,469}

If symptoms of poor sleep are present, also ask about the client's:⁴⁷⁰

- Sleep history.
- Leg movements during sleep.
- Grief or recent loss.
- Level of physical activity during the day.
- Caffeine intake.
- Alcohol consumption.
- Need to use the bathroom during the night.

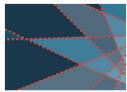
Several medication and nonmedication treatments can improve sleep problems. Depending on symptom severity, the medical provider conducting this part of the assessment may consult with a sleep medicine specialist for an indepth assessment or with a psychologist for behavioral management of symptoms. A full assessment of sleep should include an assessment for sleep apnea, which may involve an in-home or in-clinic overnight sleep study. Sleep problems that result from a physical condition or medication can usually be treated by addressing the medical illness and by switching medication or adjusting the dose.

Chronic pain

Chronic pain can be hard to manage in any client. But in clients who misuse or are at risk of misusing substances, managing chronic pain becomes even more difficult. This is because substance use can often affect chronic pain in positive ways, even though the substance itself is harmful. For example, many older clients start taking pain medication to reduce physical discomfort. However, they may continue taking the medication to also manage emotional pain or to reduce withdrawal symptoms that occur when they try to stop taking it. Clients may misuse both prescribed and nonprescribed substances, such as alcohol, for such reasons.

People with chronic pain may be at risk for substance misuse. This is not surprising given that substances like opioids, alcohol, and cannabis can help reduce physical pain. The following are findings from several studies of older adults:

- In Wave 3 of the National Epidemiologic Survey on Alcohol and Related Conditions, adults ages 50 and older who engaged in nonmedical cannabis use were significantly more likely also to report past-year injuries, greater pain interference, and nonmedical pain reliever use compared with those not using cannabis.⁴⁷¹ The study authors suggest that, in some older adults, nonmedical substance use and misuse may reflect their efforts to reduce pain without help from doctors.
- Having numerous painful medical conditions, or more severe pain, was associated with a 15-percent to 20-percent increased chance of having physical, mental, or social problems related to drinking.⁴⁷² Older adults with pain severe enough to interfere with ADLs were especially likely to have alcohol-related problems.⁴⁷³
- Using alcohol to self-medicate pain is associated with greater pain intensity, greater pain interference with everyday activities, and higher levels of depression and anxiety compared with not using alcohol to self-medicate pain.⁴⁷⁴



Older clients are likely to underreport their pain.⁴⁷⁵ Using a two-step approach will help you thoroughly assess for chronic pain in older clients:

- **First, ask your clients directly about their pain.**
 - Self-report is the most reliable method of assessing pain in older people.⁴⁷⁶ Even most clients with mild-to-moderate cognitive impairment can accurately tell you about their pain.⁴⁷⁷
 - Open-ended questions (“Tell me about your aches and sores,” or “Tell me about any discomfort you are having”) may be more useful than yes/no questions (“Are you feeling any pain?”).⁴⁷⁸
 - You should try using words other than “pain,” because some older adults will not report feeling pain.⁴⁷⁹ Instead, you can use words like “discomfort,” “aches,” “hurt,” and “sore.”
- **Second, use a pain rating scale to learn the intensity of your client’s pain.**
 - The revised Iowa Pain Thermometer (IPT-R; see the Chapter 3 Appendix) and the revised Faces Pain Scale (see the Chapter 3 Appendix) are approved for use in older adults, including those from diverse racial and ethnic populations.⁴⁸⁰ The IPT-R can also be used with older adults with cognitive impairment.⁴⁸¹
 - Verbal descriptor scales (VDS; Exhibit 3.9) can be used with older adults with and without cognitive impairment.⁴⁸² These scales come in two main types.⁴⁸³ One type asks clients to rate their pain only using words, such as “none,” “mild,” “moderate,” or “extreme.” The second type asks clients to rate their pain using a number scale. The number scale usually ranges from 0 to 5 or 0 to 6.

All three of these tools (the IPT-R, the revised Faces Pain Scale, and VDS instruments) are easy to use and easy for older clients to understand. Although pain scales can be useful, do not rely on them alone. Assessment and treatment planning should consider not just how a client rates on a pain scale but also his or her level of functioning in the presence of pain.

EXHIBIT 3.9. Verbal Descriptor Scales (VDS)^{484,485}

(Word-based scale) Please describe your pain from “no pain” to “slight,” “mild,” “moderate,” “severe,” “extreme,” or “pain as bad as it could be.”

(Number-based scale) Please describe your pain using these numbers: 0 for no pain, 1 for slight pain, 2 for mild pain, 3 for moderate pain, 4 for severe pain, 5 for extreme pain, and 6 for the most intense pain imaginable.

Older clients with chronic pain can be treated effectively. However, giving older clients prescription opioid medications to treat chronic pain raises concerns. That’s because:

- **Little evidence exists that opioids offer long-term relief of chronic noncancer pain in older adults.**⁴⁸⁶ Nonopioid medications, like acetaminophen and topical nonsteroidal anti-inflammatory drugs (NSAIDs), can be effective for certain conditions and are alternatives to opioid medications.⁴⁸⁷
- **Compared with younger adults, older adults have a higher risk of harmful drug–drug interactions** because they often take one or more prescribed medications for chronic illnesses. The combination of opioid medications and alcohol is also very dangerous in older people. (See the CDC’s factsheet on screening for alcohol use before prescribing opioids at www.cdc.gov/drugoverdose/pdf/prescribing/AlcoholToolFactSheet-508.pdf.)
- **Long-term opioid use can increase the risk for certain negative physical conditions.** These conditions include breathing problems and hormone changes for older adults.⁴⁸⁸
- **This age group is also at risk for opioid misuse and addiction.**⁴⁸⁹ In 2018, more than 9,200 opioid overdose deaths occurred among people ages 55 and older.⁴⁹⁰ From 2017 to 2018, opioid overdose deaths among people ages 65 and older increased by 14.3 percent, and deaths from prescription opioid overdose among this same age group increased by 7.4 percent.⁴⁹¹

- **Some nonmedication treatments may be beneficial and carry less risk** of harm to older adults than opioid medications, although more research is needed on these management approaches.^{492,493}

Healthcare providers and prescribers must **carefully weigh the possible benefits of opioid treatment with its risks**. For instance, healthcare prescribers should:⁴⁹⁴

- Try using nonmedication treatments in place of or along with opioid treatment.
- Use a “start low and go slow” approach to dosing.
- Check for possible drug–drug interactions with clients’ other medications.
- Discuss with clients the benefits and possible harms of taking opioids.
- Screen and assess clients for factors that increase the odds of misuse and addiction.
- Carefully monitor clients for harmful reactions.
- Educate clients about opioid-related safety issues. These include drug–drug interactions, fall risk, driving risks, and safe storage of opioid medications.
- Periodically review the ongoing need for the opioid medication, and consider whether the dose can be reduced, tapered, or discontinued.

Nonmedication and medication treatments are available to help older adults reduce their pain and improve their everyday activities and quality of life while keeping their risk of opioid misuse and addiction low. Nonopioid medication treatments for pain recommended by CDC in its 2016 *CDC Guideline for Prescribing Opioids for Chronic Pain*⁴⁹⁵ include:

- Acetaminophen.
- NSAIDs.
- Antidepressants.
- Anticonvulsants.
- Epidural injections.

In some instances, opioid medication may be appropriate and can be used safely if used within CDC guidelines for safe practices.⁴⁹⁶ However, proven nonmedication approaches to pain

management exist, such as acupuncture, cognitive–behavioral therapy, physical therapy, massage, biofeedback, and chronic pain self-management programs.

Of note, if medication is used, acetaminophen or oral NSAIDs in older adults can increase their risk of hepatic, cardiovascular, or gastrointestinal toxicity, especially when used long term, in excess, or in combination with certain other medications.^{497,498}

Psychosocial History

Substance use history

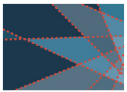
Substance use histories can help you learn the severity of a client’s substance misuse, make SUD treatment plans, discover whether potential drug interactions are present, and understand the negative consequences of the substance misuse.

Asking about the client’s history of substance use will help you learn about the individual’s severity of use and effects of that use on life. This may include asking about:

- Choice of substances used.
- Age at first use.
- The person who first introduced the client to the substance.
- Routes of taking the substance (e.g., injection, smoking).
- History of tolerance, withdrawal, mixing drugs, and overdose.
- Reasons for starting and continuing to use the substance, which may change over time.

Be sure to also ask about current patterns of use, which will help you make treatment decisions. Such questions could include:

- “How much do you drink when you do use alcohol?”
- “How often do you smoke or use tobacco?”
- “When was the last time you had a drink?”
- “Have you ever wondered whether your substance use is affecting your life or health in any way? Have you ever had a DUI?”
- “Does drinking alcohol help you feel better? (If yes) In what ways does it help you feel better? How do you feel after you have stopped drinking?”



- “Which prescription and over-the-counter medications do you take? Do any of them interact with alcohol in a way that could harm you?”

SUD treatment history

Clients’ history of seeking SUD treatment or stopping use on their own can help guide treatment planning. Also ask clients about what led to their return to substance use after having stopped for a period. Successful and unsuccessful quit attempts can help you make treatment planning decisions. Taking an SUD treatment history could include asking clients about:

- Specific settings in which they were treated (e.g., inpatient versus outpatient, criminal justice versus non-criminal justice).
- Their history of using support groups and community support and in what ways such supports were (or were not) helpful.
- Previous SUD treatments that were and were not successful. In addition, ask about periods following treatment where clients were successful (e.g., what worked for them).
- Previous attempts at stopping use, why they attempted to stop, and how many times they have tried to stop.
- Circumstances that led to the clients’ starting treatment. (Was it voluntary? Why start treatment now, today?)
- Relapse prevention and recovery strategies that worked in the past.
- How treatment ended. (Did they complete treatment or leave treatment early? If the latter, why?)

History of mental illness and mental health services

Co-occurring mental illness is very common among people who misuse substances.^{499,500} The 2019 National Survey on Drug Use and Health estimates that 49.2 percent of adults with an SUD in the past year also had a mental illness,⁵⁰¹ whereas only about 16.8 percent of adults without an SUD in the past year also had a mental illness.⁵⁰² The survey also estimates that 10.7 percent of

adults ages 50 and older with any mental illness also have an SUD.⁵⁰³ Meanwhile, an estimated 36.8 percent of adults ages 50 and older with an SUD have a co-occurring mental disorder.⁵⁰⁴

Depression, anxiety, and PTSD are especially likely to co-occur with substance misuse.^{505,506,507,508} Keep the following points in mind when you assess for these conditions:⁵⁰⁹

- Older clients may be more likely to talk about physical symptoms than emotional ones.
- You should ask about any medications the client is taking. Some medications can cause side effects that are similar to symptoms of depression (like trouble sleeping or feeling low energy).
- Depending on the client’s cognitive abilities, you may need to speak with a family member or a family caregiver to get information about the client’s mental health and history. Be sure to get permission from the client before doing this.
- Older women in particular can be easily mistaken as having depression or other mental disorders (like anxiety) instead of PTSD.⁵¹⁰
- Remember the importance of helping clients feel safe physically and emotionally.
 - Trauma and abuse can occur at any point in a person’s life. Suicide also can occur in older people. Before assessing for depression and PTSD, make sure you have a safety plan in place. This will help you respond appropriately to any client’s reports of abuse and self-harm.
 - Keeping your clients safe isn’t just the right thing to do—it’s the law. Make sure you know your state’s laws about responding to reports of abuse and self-harm.

The co-occurrence of a mental disorder and SUD can make treatment difficult and is associated with negative events. In older adults, such events include increased mortality, an increased chance of experiencing harmful medication–substance interactions, the co-occurrence of complex medical conditions (like dementia), and an increased risk of suicide.⁵¹¹ Be sure to ask clients about psychosocial symptoms they have during periods of substance misuse and abstinence.

Social history

Learning about a client's social environment and relationships can guide you in treatment planning. That is because social factors can affect whether a client stays in treatment or leaves treatment early, as well as treatment outcomes. Valuable information about the social environment includes the client's:

- Transportation.
- Caregiver needs.
- Caregiving responsibilities (e.g., whether the client cares for a child or other dependent).
- Cohabiting status (i.e., living alone versus with someone).
- Regular access to safe, secure, and stable housing.
- Criminal justice involvement.
- Employment status and quality of work setting.
- Relationships with family, friends, or close others who themselves use substances. (Get the client's consent before speaking to any of these people directly.)
- Sexual orientation, identity, and history, including risk factors for HIV and sexually transmitted infections.
- Level of safety at home, especially in terms of potential for violence. Note that substance use greatly increases the risk of intimate partner violence. Screen all women who seek SUD treatment for intimate partner abuse, regardless of their age.⁵¹² Substance use increases the risk of abuse toward older adults,⁵¹³ and experiencing elder abuse can contribute to substance misuse among older adults. If you suspect an older adult is misusing substances, screen for elder abuse.

Family history

Family can play a major role in whether a person is at risk for substance misuse. Always ask clients about the substance use histories of their parents, siblings, and partners. Family-related factors that can increase the risk of having substance misuse include:^{514,515}

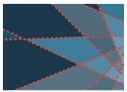
- Genetic factors.
- The home environment in which a person was raised—specifically, whether the client was exposed to substance use in the household during childhood.
- Having a first-degree relative (i.e., a parent, child, sister, or brother) who misuses substances. For instance, a person has five times the risk of developing alcohol dependence if he or she has any first-degree relative with alcohol dependence.⁵¹⁶ The client's misuse may have a basis in genetic factors, modeling of behavior of others, or both.
- Having negative or low-quality parent–child relationships in adolescence that were unsupportive and featured a lot of arguing or fighting.⁵¹⁷

Activities of Everyday Living

As people age, many sooner or later have problems completing everyday tasks on their own, like bathing, cooking, shopping, and driving. **Substance misuse can make everyday living even more difficult, including ADLs and instrumental activities of daily living (IADLs).** ADLs are basic everyday tasks like dressing, using the toilet, using the phone, and feeding oneself. IADLs are more complex tasks that need more skills to complete. They include balancing a checkbook, shopping, cooking, and driving. **As part of assessing substance misuse, measure clients' ability to complete ADLs and IADLs without help. This will paint a full picture of the effects of substance misuse.**

Katz Index of Independence in Activities of Daily Living

The Katz Index of Independence in Activities of Daily Living (Katz ADL; see the Chapter 3 Appendix)⁵¹⁸ is one of the most commonly used measures of ADLs. It assesses performance in six areas: bathing, dressing, toileting, transferring, continence, and feeding.



Barthel Index

Like the Katz ADL, the Barthel Index is a brief, widely used screener for ADLs.^{519,520} It measures a person's ability to perform the following: feeding, bathing, grooming, dressing, toileting, controlling bladder and bowels, transfers, mobility, and using the stairs. Unlike the Katz ADL, the Barthel Index collects information from three sources—clients, their caregivers, and direct observation—to see whether older adults can complete activities without help.

Functional Activities Questionnaire

The Functional Activities Questionnaire is a measure of IADLs.^{521,522} It is completed by a person (usually an adult family member) who knows the client well, has seen the client's behavior, and can assess the client's ability to complete IADLs and how much assistance the client needs to complete them, if any.

Fall Risk Assessment

Older people are at an increased risk of falling, and substance misuse can increase this risk.

Falling is the number one cause of injury among people ages 65 and older.⁵²³ Each year, more than 800,000 adults are hospitalized for a fall.⁵²⁴ Between 30 and 40 percent of adults in the community (that is, not in a hospital) ages 65 and older fall at least once each year. In 2014 alone, older Americans had approximately 29 million falls, which resulted in roughly 7 million injuries.⁵²⁵ Falls are not only potentially dangerous, they can be expensive as well. The direct cost of care for nonfatal fall-related injuries in older adults in the United States is estimated to be more than \$31 billion a year.⁵²⁶

Physical and mental conditions (including substance misuse) that can increase an older person's fall risk include:^{527,528,529,530,531,532}

- Dementia.
- Delirium.
- Cognitive problems in general.
- Depression.
- Poor sleep.

- Use of multiple medications, especially antidepressants.
- Benzodiazepine use.
- Excessive alcohol use.

How do you know which client does and does not need a fall assessment? The American Geriatrics Society and the British Geriatrics Society⁵³³ suggest you **ask yourself three simple questions:**

- Has the client had two or more falls in the past year?
- Has the client had a recent fall?
- Does the client have trouble with walking or balance?

If you answered "yes" to any of these questions, you may want to assess the client for fall risk.

Timed Up & Go Test

The CDC's Timed Up & Go is one of the easiest ways to assess a client's fall risk. This test measures a person's ability to stand from a sitting position, walk a short distance (10 feet), turn around, and walk back to where the individual was sitting. Instructions for how to give the Timed Up & Go are available online (www.cdc.gov/steady/pdf/TUG_Test-print.pdf).

Determining Diagnosis and Severity of an SUD

Because diagnosing SUDs in older adults differs from diagnosing SUDs in younger adults, try:

- Using DSM-5 criteria to make an SUD diagnosis.⁵³⁴ Using an SUD assessment instrument based on DSM-5 criteria will improve diagnostic accuracy. However, not all DSM-5 diagnostic criteria apply to older adults. Always use clinical judgment when making an SUD diagnosis.
- Using diagnostic decision trees made specifically for SUD in older clients.
- Making a treatment plan only after getting a positive substance misuse screen, completing a full assessment, and making a diagnosis of SUD.

- Knowing how to keep older adults interested and willing participants in the screening and assessment process (e.g., knowing what to say to older clients and how to say it).

If diagnostic criteria are met, also find out the severity of the diagnosis. You can do this by counting the number of DSM-5 SUD criteria met by the client's symptoms.⁵³⁵

- A mild SUD is present when 2 or 3 of the 11 SUD diagnostic criteria are met.
- A moderate SUD is present when 4 or 5 criteria are met.
- A severe SUD is present when 6 or more criteria are met.

Keep in mind that DSM-5 criteria should be interpreted in an age-appropriate manner. (See Chapter 4 for examples of how DSM-5 criteria for AUD might not be age appropriate.) For instance, tolerance is a DSM-5 criterion for an SUD diagnosis. But older people are more likely to achieve tolerance faster and on smaller amounts of the substance than younger adults. Therefore, tolerance in an older individual does not necessarily mean that they are dependent on the substance. Also remember that symptoms of SUDs are often the same as symptoms of other physical diseases and mental disorders. You must rule out these other mental and physical disorders before making an SUD diagnosis.

Remember that **not every addiction treatment provider is qualified to make a mental disorder diagnosis.** If you do not have the training and licensure to make diagnoses, send the client to another provider in your program who can. If no one in your program has the required qualifications, refer the client to another program that does. Integrated programs can be particularly effective at meeting older adults' full range of biopsychosocial needs and may be a suitable referral option. When possible, help facilitate these referrals by offering a "warm handoff" of clients to the referred provider, which helps ensure that clients are able to successfully access mental health services.

Treatment Planning, Referrals, and Treatments

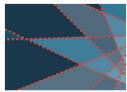
Treatment Planning

Treatment planning includes preparing to **provide treatment or refer to the most appropriate treatment provider.** You should start with treatment planning, and then either give the treatment or refer to an outside provider if your program cannot provide the services or level of care the client needs. Although rare, age-specific treatment settings and programs may provide the most effective care for older clients.

The foundation of treatment planning is individualized assessment. This should be done systematically with a tool such as the Level of Care Utilization System for Psychiatric and Addiction Services (LOCUS 20).⁵³⁶ LOCUS allows the user to characterize the following dimensions based on client strengths, challenges, resources, and risks and produce a specific rating:

- Risk of Harm
- Functional Status
- Medical, Addictive and Psychiatric Co-Morbidity
- Recovery Environment both in terms of level of stress and level of support
- Treatment and Recovery History
- Engagement and Recovery Status

For older adults, be sure to think also about age-related factors when making decisions about where to place the client for treatment. For example, if a client uses a wheelchair, you will want to select a treatment setting that the individual can access. Clients who are Deaf or Hard of Hearing may need individual therapy, small-group therapy tailored to their hearing needs, or both. LOCUS 20 describes six broadly defined levels of care and provides a decision tree and grid to help you map the multidimensional assessment of the client to the level of care most likely to meet their needs. The six levels of care are:



- Recovery Maintenance/Health Management.
- Low Intensity Community Based Services.
- High Intensity Community Based Services.
- Medically Monitored Non-Residential Services.
- Medically Monitored Residential Services.
- Medically Managed Residential Services.

The LOCUS 20 tool can be downloaded for free from www.communitypsychiatry.org/resources/locus.

Using Shared Decision Making

Shared decision making helps people who are receiving treatment for or in recovery from an SUD feel more involved in their own care. Decision making should involve the client in determining preferences for treatment. Statements like those below can help clients participate in the shared decision-making process:

- “I want to work with you to find the best treatment setting possible for you and your needs.”
- “Let’s see what your spouse and brother think about these treatment options.” (Be sure to get the client’s consent before speaking with family.)
- “Let’s review your smoking cessation options so that you know everything that is available to you.”
- “Many people do not understand what ‘intensive outpatient addiction treatment’ means. Let’s talk about that so I can clear up any misunderstandings and answer any questions you might have.”
- “You said you would like to hear more about inpatient detoxification. Let me review with you the admission requirements so we can figure out whether this type of setting is best for you.”
- “I know we talked about many treatment options today. Why don’t you tell me what you think would be the best fit, and then I can share with you my thoughts about the best option. I’ll bet we can find something we both agree on.”

When cognitive impairment is present, you may need to adapt these statements to elicit an older adult’s feedback. Nonetheless, best practices suggest that service providers, healthcare

professionals, and guardians maximize each individual’s input in the healthcare decision-making process.^{537,538}

Research supports involving clients with SUDs in treatment decision-making processes.⁵³⁹ In some cases, matching clients’ substance-related treatment preferences has led to improved outcomes.⁵⁴⁰ However, shared decision making in the context of SUDs can be challenging. Clients who have SUDs may have mixed feelings about whether they can, or even want to, stop using substances. This is where MI can be a useful tool.

MI

Motivational interviewing is a client-centered approach to treatment planning that can be used with shared decision making. Combined, these methods can help clients feel confident in their treatment decisions and ability to change their substance misuse.⁵⁴¹

MI has been reported to be effective for people with many different health conditions, including SUDs.⁵⁴² It has been used successfully with older adults to help improve physical health and health-related behaviors (e.g., weight loss, exercise) as well as substance misuse (including alcohol misuse and tobacco use).⁵⁴³ MI can help clients:⁵⁴⁴

- Address any mixed feelings they have about entering treatment.
- Explore their thoughts about changing their behaviors, such as cutting down on alcohol use or monitoring their prescription medication intake.
- Develop personal and meaningful reasons for wanting to change their behaviors.
- Create an action plan for how they will change their behaviors.

Referrals

If your program cannot offer treatment for SUDs, refer your clients to counseling and tailored psychosocial supports that have the capacity to meet older adults’ unique needs. You should refer to the level of care that is the least intense yet will address all the client’s needs. The following paragraphs describe several options.

A safe withdrawal is the first order of business. If detoxification is needed, that will be the first referral indicated, whether inpatient or outpatient.

Develop a plan for seamless transitions between services and warm patient handoffs.

Refer for SUD treatment and mental health services as needed. You may need to refer the client to an outside provider for SUD treatment if your setting cannot offer the level of care or types of services the client's symptoms warrant. For example, a client may need inpatient drug and alcohol rehabilitation, but your program only offers outpatient care.

Referral to mental health services is appropriate if the severity or type of mental illness is beyond what you can treat. Clients with depression, PTSD, or other mental disorders may be more likely to succeed in addiction treatment if those conditions are managed.

When considering referral for treatment, first consider the client's thinking abilities.

Problems with thinking could affect a client's ability to participate in treatment. The client might need a treatment provider who has experience working with older clients with cognitive problems. Individual treatment rather than group treatment might also be a better choice.

Even if you refer to formal SUD treatment elsewhere, you can still support the client. Follow up with him or her by periodically asking about current substance use and progress in treatment.

Use these questions as an opportunity to identify clients at risk for relapse while offering positive reinforcement in a warm and nonjudgmental manner. Addiction treatment providers can also provide ongoing support and encouragement to older clients who enter the formal treatment system by:

- Learning about treatment resources in the community that offer appropriate services. (See "Resource Alert: Making the Most of Your Referral Resources.")

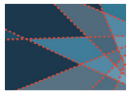
- Keeping in touch with the client's specific treatment program. This can help you make sure the program is offering appropriate care. It will also help you understand the approach and services the program offers so you can appropriately refer future clients there.
- Asking the treatment program to share with you, from time to time, reports about the treatment plan and how the client is doing in treatment. (Get the client's written permission before doing so.)
- Stressing the importance of continuing with treatment when discussing progress with the client.

Make referrals to medical services that provide respectful, consistent physical health care. This can help clients recover from substance misuse. As with any client, you should make appropriate referrals for medical care that is beyond what your practice setting offers.

Make referrals to mutual-help groups for clients who wish to join such groups in addition to receiving addiction treatment or mental health services. These programs can offer clients social support and encouragement to help them avoid substance misuse. (See "Mutual-Help Programs" below.)

Make referrals to additional services that meet clients' needs. In addition to SUD treatment, mental health, and medical services, older adults who have SUDs may need additional support in certain areas. They may benefit from help in areas like:

- Case management.
- Food access.
- Housing.
- Transportation.
- Legal assistance.
- In-home services and supports to facilitate completing ADLs and IADLs.
- Insurance-related needs (e.g., assistance enrolling in Medicare, Medicaid, or both).



RESOURCE ALERT: MAKING THE MOST OF YOUR REFERRAL RESOURCES

Having a collection of substance-related treatment referral resources on hand will help you give clients more options and better access to care. Ask yourself the following questions to help make the most of the available referral resources.

What specialized SUD treatment programs are in my community?

Most communities have a public or private agency that keeps a directory of SUD treatment programs. This directory can give useful information about program facilities (e.g., type, location, hours, accessibility to public transportation), services, eligibility criteria, cost, and staff experience, including languages spoken. Each state also has a single state-level alcohol and drug agency that oversees the licensing and program review for all SUD treatment programs in that state. This agency often offers a statewide directory of all SUD treatment programs licensed in the state.

- You can find SUD treatment facilities by using <https://findtreatment.gov/>.
- SAMHSA offers a Behavioral Health Treatment Services Locator (<https://findtreatment.samhsa.gov/>) and a National Directory of Drug and Alcohol Abuse Treatment Facilities (https://www.samhsa.gov/data/sites/default/files/reports/rpt23267/National_Directory_SA_facilities.pdf).

Who are my local resources and points of contact? Reach out to local resources and introduce yourself. Learn what services they offer. This will help you get clients into the system of care more quickly.

What mutual-help groups are in my community? What do they offer older clients specifically? Keep on hand names of mutual-help groups that can meet older clients' age-related needs. For instance, Seniors In Sobriety (SIS) (www.seniorsinsobriety.com) is a part of Alcoholics Anonymous (AA). SIS maintains an online list of SIS and senior-friendly AA meetings in several states (<http://www.seniorsinsobriety.com/wp-content/uploads/2019/03/SISMeetings-Mar2019.pdf>).

Treatments

Older adults can and do benefit from SUD treatment, although less is known about what works for older adults than for other age groups.⁵⁴⁵

Older adults who get SUD treatment may show the same levels of abstinence as younger adults.⁵⁴⁶ In some cases, older adults have had even more success than younger adults.^{547,548}

More treatment (e.g., more outpatient sessions, longer inpatient stays) can improve older adults' treatment outcomes.

Mental Health Services

A range of mental health interventions exist for older adults who misuse substances. Effective psychosocial treatments and levels of care that have worked for older clients include:^{549,550,551,552}

- Motivational enhancement.
- Cognitive-behavioral therapy.
- Individual and group therapy.

- Supportive therapy.
- Pharmacological treatments.
- Couples and family therapy.
- Brief advice or targeted education.
- Telephone-based brief interventions.
- Relationship enhancement therapy.
- Case management.
- Outpatient treatment.
- Inpatient treatment.

Many of these treatments can also address MDD, PTSD, and other CODs in older clients who misuse substances. To get the best results, recommend mental health services that meet older adults' special needs. Age-related needs often relate to the unique stressors and life events, like retirement, death of a significant individual, or moving into a nursing home, that older adults are likely to experience.

Mutual-Help Programs

Well-known mutual-help programs include the 12-Step programs AA and Narcotics Anonymous. Many other peer-recovery support groups are available as well, like:

- Women for Sobriety.
- SMART (Self-Management and Recovery Training) Recovery.
- LifeRing Secular Recovery.
- Secular Organizations for Sobriety/Save Our Selves.
- Celebrate Recovery.
- Double Trouble in Recovery (for people with CODs).
- Dual Recovery Anonymous (for people with CODs).

Mutual-help programs offer older adults a network of peers with whom they can relate. These groups help older adults share common experiences in substance misuse and recovery. Mutual-help programs also help keep clients socially active and reduce loneliness. These groups and their availability vary greatly in various parts of the county. Some will not be available in many localities, but online and telephone meetings may be available.

Finding local mutual-help programs that are only for older adults can be difficult. Instead, try to find local groups that are open to adjusting their sessions toward older clients and their needs (e.g., using a slower pace, being willing to discuss life-stage changes and loss). You should also look for local groups that already have older-age attendees.⁵⁵³

RESOURCE ALERT: AA AND OLDER ADULTS

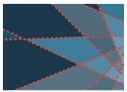
AA offers a large-print handout for older adults interested in attending an AA meeting. This handout is titled *A.A. for the Older Alcoholic—Never Too Late*. Consider sharing this with older clients who misuse alcohol and express an interest in learning more about 12-Step programs.

(Available at www.aa.org/assets/en_US/p-22_AAfortheOlderAA.pdf)

Summary

A well-thought-out approach to comprehensive screening and assessment will help you identify older adults with or at risk for substance misuse and related conditions. This is an important step in making sure clients get the right diagnosis and timely treatment (or treatment referral). The many screening tools approved for use with older adults can help you detect substance misuse. In addition, numerous measures can help you identify conditions common in older people with substance misuse. These conditions include problems with thinking, depression, anxiety, PTSD, elder abuse, sleep problems, chronic pain, struggles with ADLs, and risk of falling. In-depth assessments allow you to better understand the full range of factors in clients' substance misuse. Screening and assessment results contribute to client-centered care by helping you offer treatment options that meet clients' individual symptoms, risk factors, treatment needs, and treatment preferences.

Remember that a wide range of providers in many different settings can be involved in helping to identify, screen, and assess older clients for substance misuse. There's no "wrong door" through which older adults can receive a diagnosis and the treatment they need.



Chapter 3 Resources

Alcohol and Drug Use Screening

National Institute on Alcohol Abuse and Alcoholism (NIAAA)—Professional Education Materials (www.niaaa.nih.gov/publications/clinical-guides-and-manuals): NIAAA offers links to screening, treatment planning, and general information for clinicians in outpatient programs.

NIDA—NIDAMED: Clinical Resources (www.drugabuse.gov/nidamed-medical-health-professionals): This webpage offers resources for healthcare professionals on the effects of substance misuse on clients' health and on ways to identify substance use early and prevent it from turning into misuse.

Tobacco Screening and Cessation

Agency for Healthcare Research and Quality—Five Major Steps to Intervention (www.ahrq.gov/prevention/guidelines/tobacco/5steps.html): The agency provides guidance to clinicians for using the “5 A’s” approach (Ask, Advise, Assess, Assist, Arrange) for determining whether clients are ready and willing to quit tobacco use.

CDC—Smoking & Tobacco Use (www.cdc.gov/tobacco/index.htm): CDC offers resources and information for clients and clinicians, including links to factsheets, tobacco prevention and control data, and clinical tools.

HHS—BeTobaccoFree.gov (<https://betobaccofree.hhs.gov/>): People with nicotine addiction can use this website to connect with counselors, get free text messages supporting their efforts to quit, and download smartphone apps to help them stay smoke free. The site also links to federal reports and research on tobacco use.

HHS—Million Hearts Initiative: Tobacco Use (<https://millionhearts.hhs.gov/tools-protocols/tools/tobacco-use.html>): Providers can use the tools on this webpage to improve the tobacco use interventions they undertake as part of clinical care.

MaineHealth Center for Tobacco Independence—Provider Tobacco Treatment Tools (<https://ctimaine.org/resources/provider-tools/>): The center makes available the Fagerström screening tools for nicotine dependence, including dependence on smokeless

tobacco. The center's webpage also includes other assessment tools, motivational documents, and information on tobacco treatment medications and treatment in group settings.

University of California, San Francisco Smoking Cessation Leadership Center—Toolkits (<https://smokingcessationleadership.ucsf.edu/resources/toolkits>): This webpage has downloadable provider toolkits on tobacco screening and cessation from a variety of sources, including the American Lung Association and CDC.

Referral and Treatment Locators

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—Opioid Treatment Program Directory (<https://dpt2.samhsa.gov/treatment/directory.aspx>): SAMHSA provides a state-by-state directory of opioid treatment programs.

SAMHSA—Your Recovery Is Important: Virtual Recovery Resources (www.samhsa.gov/sites/default/files/virtual-recovery-resources.pdf): This listing of virtual recovery resources includes mutual-help groups with online meetings.

Treatment Planning

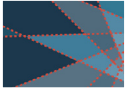
SAMHSA—Decisions in Recovery: Treatment for Opioid Use Disorder (<https://mat-decisions-in-recovery.samhsa.gov/>): People with opioid use disorder can use this website's interactive tool to make informed decisions about their care. The site also includes links to a video library, recovery tools, and other recovery-related resources.

Chapter 3 Appendix

Alcohol Use Disorders Identification Test (AUDIT): Interview Version

Read questions as written. Record answers carefully. Begin the AUDIT by saying “Now I am going to ask you some questions about your use of alcoholic beverages during this past year.” Explain what is meant by “alcoholic beverages” by using local examples of beer, wine, vodka, etc. Code answers in terms of “standard drinks.” Place the correct answer number in the box at the right.

<p>1. How often do you have a drink containing alcohol?</p> <p>(0) Never [Skip to Qs 9-10] (1) Monthly or less (2) 2 to 4 times a month (3) 2 to 3 times a week (4) 4 or more times a week</p> <input type="text"/>	<p>6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?</p> <p>(0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily</p> <input type="text"/>
<p>2. How many drinks containing alcohol do you have on a typical day when you are drinking?</p> <p>(0) 1 or 2 (1) 3 or 4 (2) 5 or 6 (3) 7, 8, or 9 (4) 10 or more</p> <input type="text"/>	<p>7. How often during the last year have you had a feeling of guilt or remorse after drinking?</p> <p>(0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily</p> <input type="text"/>
<p>3. How often do you have six or more drinks on one occasion?</p> <p>(0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily</p> <p><i>Skip to Questions 9 and 10 if Total Score for Questions 2 and 3 = 0</i></p> <input type="text"/>	<p>8. How often during the last year have you been unable to remember what happened the night before because you had been drinking?</p> <p>(0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily</p> <input type="text"/>
<p>4. How often during the last year have you found that you were not able to stop drinking once you had started?</p> <p>(0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily</p> <input type="text"/>	<p>9. Have you or someone else been injured as a result of your drinking?</p> <p>(0) No (2) Yes, but not in the last year (4) Yes, during the last year</p> <input type="text"/>
<p>5. How often during the last year have you failed to do what was normally expected from you because of drinking?</p> <p>(0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily</p> <input type="text"/>	<p>10. Has a relative or friend or a doctor or another health worker been concerned about your drinking or suggested you cut down?</p> <p>(0) No (2) Yes, but not in the last year (4) Yes, during the last year</p> <input type="text"/>
<p>Record total of specific items here</p> <input type="text"/>	
<p>Scoring: The cutoff score indicating hazardous and harmful alcohol use for the AUDIT is generally 8; however, for older adults a score of 5 indicates a need for clarifying questions and further assessment.⁵⁵⁴</p> <p><i>Adapted from Barbor et al. (2001).⁵⁵⁵</i></p>	



Alcohol Use Disorders Identification Test-C (AUDIT-C)

Patient Name: _____ Date: _____

1. How often do you have a drink containing alcohol?

- ☐ a. Never
- ☐ b. Monthly or less
- ☐ c. 2-4 times a month
- ☐ d. 2-3 times a week
- ☐ e. 4 or more times a week

2. How many drinks containing alcohol did you have on a typical day when you were drinking in the past year?

- ☐ a. 0 drinks
- ☐ b. 1 or 2
- ☐ c. 3 or 4
- ☐ d. 5 or 6
- ☐ e. 7 to 9
- ☐ f. 10 or more

3. How often do you have six or more drinks on one occasion?

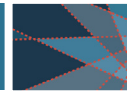
- ☐ a. Never
- ☐ b. Less than monthly
- ☐ c. Monthly
- ☐ d. Weekly
- ☐ e. Daily or almost daily

The AUDIT-C is a much shorter version of the AUDIT that can help you identify alcohol misuse in your clients. It contains only three questions, which add up to a total score of 0–12. A higher score usually means the client is engaging in more hazardous alcohol use. The AUDIT-C is scored as follows:

- For Questions 1 and 3, assign 0 points to response a, 1 point to response b, 2 points to response c, 3 points to response d, and 4 points to response e.
- For Question 2, assign 0 points to responses a and b, 1 point to response c, 2 points to response d, 3 points to response e, and 4 points to response f.

A total score of 3 or higher for women and 4 or higher for men means problematic alcohol use. In such cases, you should assess further (or refer for formal assessment) to learn more about the client's drinking habits and determine whether AUD is present. Learn more about the AUDIT-C, including how to score and interpret results, at www.queri.research.va.gov/tools/alcohol-misuse/alcohol-faqs.cfm#top.

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Short Michigan Alcoholism Screening Test-Geriatric Version (SMAST-G)

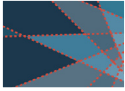
	Yes (1)	No (0)
1. When talking with others, do you ever underestimate how much you drink?		
2. After a few drinks, have you sometimes not eaten or been able to skip a meal because you didn't feel hungry?		
3. Does having a few drinks help decrease your shakiness or tremors?		
4. Does alcohol sometimes make it hard for you to remember parts of the day or night?		
5. Do you usually take a drink to relax or calm your nerves?		
6. Do you drink to take your mind off your problems?		
7. Have you ever increased your drinking after experiencing a loss in your life?		
8. Has a doctor or nurse ever said they were worried or concerned about your drinking?		
9. Have you ever made rules to manage your drinking?		
10. When you feel lonely, does having a drink help?		

TOTAL SMAST-G-SCORE (0-10) _____

SCORING: 2 OR MORE "YES" RESPONSES IS INDICATIVE OF AN ALCOHOL PROBLEM.

Ask the extra question below but do not calculate it in the final score.
 Extra question: Do you drink alcohol and take mood or mind-altering drugs, including prescription tranquilizers, prescription sleeping pills, prescription pain pills, or any illicit drugs?

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Senior Alcohol Misuse Indicator (SAMI)

1a. Have you recently (in the last few months) experienced problems with any of the following (if yes, please check box):

- | | | |
|--|---|--|
| <input type="checkbox"/> Changes in sleep? | <input type="checkbox"/> Changes in appetite or weight? | <input type="checkbox"/> Dizziness? |
| <input type="checkbox"/> Drowsiness? | <input type="checkbox"/> Difficulty remembering things? | <input type="checkbox"/> Poor balance? |
| | | <input type="checkbox"/> Falls? |

1b. Have you recently (in the last few months) experienced problems with any of the following (if yes, please check box):

- | | | |
|---|--|---|
| <input type="checkbox"/> Feelings of sadness? | <input type="checkbox"/> Lack of interest in daily activities? | <input type="checkbox"/> Feelings of worthlessness? |
| <input type="checkbox"/> Loneliness? | <input type="checkbox"/> Feelings of anxiety? | |

2. Do you enjoy wine/beer/spirits? Which do you prefer?

3. As your life has changed, how has your use of [selected] wine/beer/spirits changed?

4. Do you find you enjoy [selected] wine/beer/spirits as much as you used to?

(For clinical use. Not included in scoring.)

☐ Yes ☐ No

5. You mentioned that you have difficulties with _____ (from answers to questions 1a and b). I am wondering if you think that [selected] wine/beer/spirits might be connected? ☐ Yes ☐ No

SCORING KEY

Single responses (a score of 1 for each response):

Question 2:

I enjoy **all three** of wine/beer/spirits OR

I enjoy **a combination of any two** from wine/beer/spirits ☐

Question 3:

I have **increased** alcohol consumption from when I was younger ☐

Question 5:

Yes, there **may be** a connection between my alcohol use and health ☐

SUBTOTAL 1 = _____ /3

Multiple responses (a score of 1 for each combination of responses):

Question 2 & 3:

Yes, I do enjoy alcohol

There has been **no change** in alcohol consumption
=> If both responses provided, check box => ☐

Question 1, 2 & 3:

Yes, I have experienced **5 or more** symptoms

Yes, I do enjoy alcohol

Indicates any current alcohol consumption (regardless of any change in pattern)

=> If all three responses provided, check box => ☐

SUBTOTAL 2 = _____ /2

TOTAL SCORE = SUBTOTAL 1 + SUBTOTAL 2 = _____

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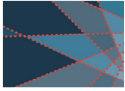
Cannabis Use Disorder Identification Test-Revised (CUDIT-R)

Have you used any cannabis over the past six months? YES/NO

If YES, please answer the following questions about your cannabis use. Circle the response that is most correct for you in relation to your cannabis use *over the past six months*.

- | | | | | | |
|-----------------------------------|-------|-----------------|-------------------|------------------|------------------------|
| 1. How often do you use cannabis? | Never | Monthly or less | 2-4 times a month | 2-3 times a week | 4 or more times a week |
| | 0 | 1 | 2 | 3 | 4 |
-
- | | | | | | |
|--|-------------|--------|--------|--------|-----------|
| 2. How many hours were you “stoned” on a typical day when you had been using cannabis? | Less than 1 | 1 or 2 | 3 or 4 | 5 or 6 | 7 or more |
| | 0 | 1 | 2 | 3 | 4 |
-
- | | | | | | |
|--|-------|-------------------|---------|--------|-----------------------|
| 3. How often during the past 6 months did you find that you were not able to stop using cannabis once you had started? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |
| | 0 | 1 | 2 | 3 | 4 |
-
- | | | | | | |
|---|-------|-------------------|---------|--------|-----------------------|
| 4. How often during the past 6 months did you fail to do what was normally expected from you because of using cannabis? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |
| | 0 | 1 | 2 | 3 | 4 |
-
- | | | | | | |
|--|-------|-------------------|---------|--------|-----------------------|
| 5. How often in the past 6 months have you devoted a great deal of your time to getting, using, or recovering from cannabis? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |
| | 0 | 1 | 2 | 3 | 4 |
-
- | | | | | | |
|--|-------|-------------------|---------|--------|-----------------------|
| 6. How often in the past 6 months have you had a problem with your memory or concentration after using cannabis? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |
| | 0 | 1 | 2 | 3 | 4 |
-
- | | | | | | |
|--|-------|-------------------|---------|--------|-----------------------|
| 7. How often do you use cannabis in situations that could be physically hazardous, such as driving, operating machinery, or caring for children? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |
| | 0 | 1 | 2 | 3 | 4 |
-
- | | | | |
|---|-------|-----------------------------------|-------------------------------|
| 8. Have you ever thought about cutting down, or stopping, your use of cannabis? | Never | Yes, but not in the past 6 months | Yes, during the past 6 months |
| | 0 | 2 | 4 |

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Penn State Worry Questionnaire (PSWQ)

Instructions: Rate each of the following statements on a scale of 1 ("not at all typical of me") to 5 ("very typical of me"). Please do not leave any items blank.

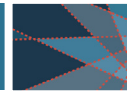
	Not at all typical of me				Very typical of me
1. If I do not have enough time to do everything, I do not worry about it.	1	2	3	4	5
2. My worries overwhelm me.	1	2	3	4	5
3. I do not tend to worry about things.	1	2	3	4	5
4. Many situations make me worry.	1	2	3	4	5
5. I know I should not worry about things, but I just cannot help it.	1	2	3	4	5
6. When I am under pressure I worry a lot.	1	2	3	4	5
7. I am always worrying about something.	1	2	3	4	5
8. I find it easy to dismiss worrisome thoughts.	1	2	3	4	5
9. As soon as I finish one task, I start to worry about everything else I have to do.	1	2	3	4	5
10. I never worry about anything.	1	2	3	4	5
11. When there is nothing more I can do about a concern, I do not worry about it anymore.	1	2	3	4	5
12. I have been a worrier all my life.	1	2	3	4	5
13. I notice that I have been worrying about things.	1	2	3	4	5
14. Once I start worrying, I cannot stop.	1	2	3	4	5
15. I worry all the time.	1	2	3	4	5
16. I worry about projects until they are all done.	1	2	3	4	5

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Scoring: Each of the 16 items is rated on a 5-point scale. Items 1, 3, 8, 10, and 11 are reverse scored as follows:

- Very typical of me = 1 (circled 5 on the sheet)
- Circled 4 on the sheet = 2
- Circled 3 on the sheet = 3
- Circled 2 on the sheet = 4
- Not at all typical of me = 5 (circled 1 on the sheet)

The remaining items are scored regularly. The item scores are added to produce a total score ranging from 16 to 80, with higher scores reflecting more worry. **A score of 50 or higher by an older person could mean significant worries are present**, but research on cutoff scores in older people is too limited to know for certain.⁵⁶² Do not assume that an older client who scores below 50 does not have anxiety.



Primary Care PTSD Screen for DSM-5 (PC-PTSD-5)

Sometimes things happen to people that are unusually or especially frightening, horrible, or traumatic. For example:

- a serious accident or fire
- a physical or sexual assault or abuse
- an earthquake or flood
- a war
- seeing someone be killed or seriously injured
- having a loved one die through homicide or suicide.

Have you ever experienced this kind of event?

YES

NO

If no, screen total = 0. Please stop here.

If yes, please answer the questions below.

In the past month, have you...

1. had nightmares about the event(s) or thought about the event(s) when you did not want to?

YES

NO

2. tried hard not to think about the event(s) or went out of your way to avoid situations that reminded you of the event(s)?

YES

NO

3. been constantly on guard, watchful, or easily startled?

YES

NO

4. felt numb or detached from people, activities, or your surroundings?

YES

NO

5. felt guilty or unable to stop blaming yourself or others for the event(s) or any problems the event(s) may have caused?

YES

NO

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Scoring: A score of 3 or more "yes" responses is considered positive.⁵⁶⁴



Elder Abuse Suspicion Index® (EASI®)

EASI® Questions Q.1-Q.5 asked of patient; Q.6 answered by doctor <i>(Within the last 12 months)</i>			
1) Have you relied on people for any of the following: bathing, dressing, shopping, banking, or meals?	YES	NO	Did not answer
2) Has anyone prevented you from getting food, clothes, medication, glasses, hearing aids or medical care, or from being with people you wanted to be with?	YES	NO	Did not answer
3) Have you been upset because someone talked to you in a way that made you feel shamed or threatened?	YES	NO	Did not answer
4) Has anyone tried to force you to sign papers or to use your money against your will?	YES	NO	Did not answer
5) Has anyone made you afraid, touched you in ways that you did not want, or hurt you physically?	YES	NO	Did not answer
6) Doctor: Elder abuse <u>may</u> be associated with findings such as: poor eye contact, withdrawn nature, malnourishment, hygiene issues, cuts, bruises, inappropriate clothing, or medication compliance issues. Did you notice any of these today or in the last 12 months?	YES	NO	Not sure

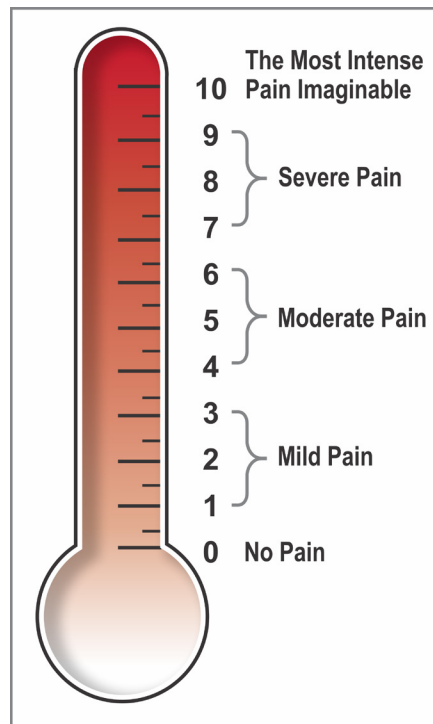
Reprinted with permission. Yaffe MJ, Wolfson C, Weiss D, Lithwick M. Development and validation of a tool to assist physicians' identification of elder abuse: The Elder Abuse Suspicion Index (EASI®). *Journal of Elder Abuse and Neglect*, 2008; 20 (3): 276-300. This tool is available online (www.mcgill.ca/familymed/research/projects/elder).

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Revised Iowa Pain Thermometer (IPT-R)

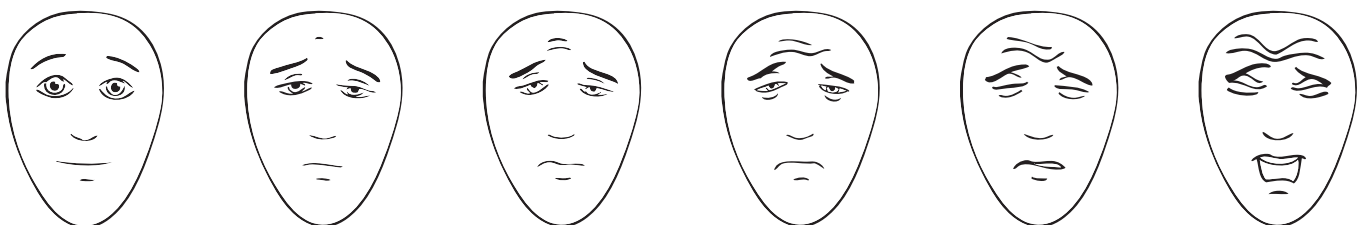


Revised Iowa Pain Thermometer (IPT-R, 2011) printed with permission. © Keela Herr, The University of Iowa.⁵⁶⁵

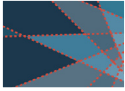
Revised Faces Pain Scale

In the following instructions, say “hurt” or “pain,” whichever seems right for a particular client. “These faces show how much something can hurt. This face [point to face on far left] shows no pain. The faces show more and more pain [point to each from left to right] up to this one [point to face on far right]—it shows very much pain. Point to the face that shows how much you hurt [right now].”

Score the chosen face 0, 2, 4, 6, 8, or 10, counting left to right. Therefore, “0” = “no pain” and “10” = “very much pain.” Do not use words like “happy” or “sad.” This scale is intended to measure how a client feels inside, not how his or her face looks.



Faces Pain Scale – Revised, ©2001, International Association for the Study of Pain [www.iasp-pain.org/FPSR]



Katz Index of Independence in Activities of Daily Living (Katz ADL)

Activities	Independence (1 Point) No supervision, direction, or personal assistance	Dependence (0 Points) With supervision, direction, personal assistance, or total care
BATHING Points: _____	(1 POINT) Bathes self completely or needs help in bathing only a single part of the body, such as the back, genital area, or disabled extremity.	(0 POINTS) Needs help with bathing more than one part of the body, getting in or out of the tub, or shower. Requires total bathing.
DRESSING Points: _____	(1 POINT) Can get clothes from closet and drawers and put on clothes and outer garments complete with fasteners. May have help tying shoes.	(0 POINTS) Needs help with dressing self or needs to be completely dressed.
TOILETING Points: _____	(1 POINT) Goes to the toilet, gets on and off, arranges clothes, and cleans genital area without help.	(0 POINTS) Needs help transferring to the toilet or cleaning self or uses bedpan or commode.
TRANSFERRING Points: _____	(1 POINT) Moves in and out of bed or chair unassisted. Mechanical transfer aids are acceptable.	(0 POINTS) Needs help in moving from bed to chair or requires a complete transfer.
CONTINENCE Points: _____	(1 POINT) Exercises complete self-control over urination and defecation.	(0 POINTS) Is partially or totally incontinent of bowel or bladder.
FEEDING Points: _____	(1 POINT) Gets food from plate into mouth without help. Preparation of food may be done by another person.	(0 POINTS) Needs partial or total help with feeding or requires parenteral feeding.
Total Points: _____ A score of 6 indicates full function; 4, moderate impairment; and 2 or less, severe functional impairment.		
Adapted from Katz, S., Down, T. D., Cash, H. R., & Grotz, R. C. Progress in the development of the index of ADL. <i>Gerontologist</i> 1970, 10(1):20–30. By permission of The Gerontological Society of America. ⁵⁶⁶		