Chapter 6—Substance Misuse and Cognitive Impairment

KEY MESSAGES

- Substance misuse can increase the risk of having cognitive problems as an older adult.
- Screening for mental disorders that co-occur with substance misuse and can negatively affect cognition is very important. Doing such screening will help you quickly get clients the substance use disorder (SUD) treatment, mental health services, and medical evaluation they need.
- Treatment should be offered as needed for the full scope of problems facing an older client. Treatment should address a client's substance misuse; co-occurring mental conditions, including depression or anxiety; and cognitive impairment.

Chapter 6 of this Treatment Improvement Protocol (TIP) will most benefit providers. It will help them understand how to screen, diagnose, and treat older clients who misuse substances and have, or are at risk for, cognitive problems. Changes in how people think and how their brains work are normal parts of getting older and vary a lot from person to person. But some age-related cognitive changes are abnormal, such as Alzheimer's disease. However, for older adults who misuse substances, difficulties with cognition and other brain functions can be more serious. Older individuals are more sensitive than younger and middle-aged adults to the negative effects of drugs and alcohol on the brain.[949] This puts older people who misuse substances at increased risk for certain problems with thinking (also called cognitive impairment or cognitive disorders), such as dementia and delirium.

Who Can Benefit From Chapter 6 of This TIP and How?

Chapter 6 of TIP 26 is for behavioral health service, healthcare, and social service providers who provide care to older adults who misuse substances. Such providers include physicians and other healthcare professionals, psychiatrists, psychologists, counselors, social workers, drug and alcohol counselors, and other behavioral health workers, such as peer recovery support specialists.

Screening, diagnosis, and treatment of older clients who misuse substances and have cognitive problems may require help from many different types of providers. One type of provider may screen; another may make the diagnosis; yet another may treat the client or work with the client's caregiver.

If you work with older adults in any setting, you are likely seeing more and more older clients who misuse substances. **Chapter 6 will support you in decreasing your clients' chances of developing dementia and other cognitive problems by helping them address substance misuse and adopt healthier lifestyles.[950,951] Chapter 6 will help you:**

- **Teach older clients** about risks of cognitive disorders related to substance misuse, such as dementia.
- **Understand why you need to screen older clients who misuse substances** for cognitive impairment, as well as conditions that co-occur with substance misuse and increase the risk for cognitive problems. These include depression, anxiety, and posttraumatic stress disorder (PTSD).

- **Refer older clients** with cognitive impairment for further cognitive testing and evaluation to make sure they receive the correct diagnosis.
- **Offer treatments** for SUDs, co-occurring mental disorders, and cognitive disorders, including education, drug and alcohol counseling, mental health services, referral for medication treatment, or a combination of these.
- **Work with caregivers** of older clients who misuse substances, have cognitive disorders, or both. Caregivers often need help improving their own coping and stress management skills. This is important because when caregivers suffer, the care they give can suffer too.

Organization of Chapter 6 of This TIP

Chapter 6 covers education, screening, assessment, and treatment of older adults who misuse substances and may also have, or be at risk for, cognitive impairment.

The first section of Chapter 6 discusses how common substance misuse is in older adults. Many people think substance misuse is "just a young person's problem." But this is not true. This section will help you understand the importance of offering substance-related screening and treatments.

The second section addresses whether substance misuse causes cognitive problems in older people. The findings from research studies are not always clear. But what is clear is why you need to look for cognitive problems in older clients who misuse substances and how you can do that.

In the third section, you will learn more about mental disorders that commonly occur in older clients who misuse substances and can negatively affect their thinking. These include depression, anxiety, and PTSD. If untreated, these conditions can also make a client's substance misuse worse. Similarly, untreated SUDs can make these co-occurring mental disorders worse.

The fourth section offers recommendations on how to help older clients who misuse substances reduce their chances of developing cognitive problems through screening, assessment, and treatment (or referral to treatment). Screening and assessment are discussed in more detail in Chapter 3 of this TIP (which includes many of the actual screening measures you can use in your program).

The fifth section guides you in helping caregivers of older clients who misuse substances and have cognitive difficulties. Caregivers face many struggles and are often in great need of information and resources—not only to help your older clients but also to help themselves.

The final section offers resources to support your program and resources to share with your clients and their family members. More detailed resources are in Chapter 9 of this TIP.

The Appendix presents two screening instruments: one for depression and another for PTSD. For definitions of key terms you will find in Chapter 6 of this TIP, see Exhibit 6.1.

EXHIBIT 6.1. 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.
- **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

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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.[952,953] 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.

- **AUD:** The fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) defines this disorder.[954] An AUD diagnosis is given to people who use alcohol and meet at least 2 of the 11 DSM-5 symptoms in a 12-month period. Key aspects of AUD include tolerance, withdrawal, loss of control, and continued use despite negative consequences. AUD covers a range of severity and replaces what the previous edition of DSM termed alcohol abuse and alcohol dependence.
- **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.[955,956] 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.[957] 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.[958] 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.
- **Cognitive disorders:** Problems in cognition that are not a normal part of aging. These problems include difficulties with memory, attention, using and understanding language, thinking and reacting quickly, solving difficult problems, or a combination of these. Dementia and MCI are examples of cognitive disorders.
- **Delirium tremens:** A temporary state of confusion that can occur during alcohol withdrawal. If untreated, some symptoms, such as unstable heart rate and seizures, can be life threatening.
- **Dementia:** A brain disorder in which problems with cognition get worse over time. Problems with cognition are serious enough that people need help with activities of everyday living (e.g., bathing, getting dressed, and feeding themselves). In DSM-5, dementia is known as major neurocognitive disorder.
- **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.[959]
- **Hazardous drinking:** Alcohol use that increases the risk of future harm.[960]
- **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.[961]
- **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).
- **MCI:** A mild brain disorder that is similar to dementia. With MCI, problems with thinking are present but are not severe enough for people to need help with their everyday activities. In DSM-5, MCI is known as mild neurocognitive disorder.
- **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.[962,963] However, the

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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.[964] 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.[965]

- **Mutual-help groups:** Groups of people who work together on obtaining and maintaining recovery. Unlike peer support (e.g., the use of recovery coaches or peer recovery support specialists), mutual-help groups consist entirely of people who volunteer their time and typically have no official connection to treatment programs. Most are self-supporting. Although 12-Step groups such as Alcoholics Anonymous and Narcotics Anonymous are the most widespread and well researched type of mutual-help groups, other groups may be available in some areas. They range from groups affiliated with a religion or church (e.g., Celebrate Recovery, Millati Islami) to purely secular groups (e.g., SMART [Self-Management and Recovery Training] Recovery, Women for Sobriety).
- **Peer support:** The use of peer recovery support specialists (e.g., someone in recovery who has lived experience in addiction plus skills learned in formal training) to provide nonclinical (i.e., not requiring training in diagnosis or treatment) recovery support services to individuals in recovery from addiction and to their families.
- **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.[966]
- **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. 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).[967] Remission is an essential element of recovery.
- **Substance misuse*:** The use of any substance in a manner, situation, amount, or frequency that can cause harm to users or to those around them. For some substances or individuals, any use would constitute misuse (e.g., underage drinking, injection drug use).
- **Substance use disorder*:** A medical illness caused by repeated misuse of a substance or substances. According to DSM-5,[968] SUDs are characterized by clinically significant impairments in health and social function and 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).

Substance Misuse in Older Adults

Substance misuse in older people is increasing,[969] yet it is often overlooked and underaddressed by providers.[970,971] Older clients may not feel comfortable telling you about their substance misuse or asking for help. This is problematic, as older people are more likely than younger or middle-aged people to experience negative effects from alcohol, drugs, and prescription medications.[972,973]

Healthcare, behavioral health service, and social service providers can have difficulty noticing substance misuse in older clients. This is partly because most older adults who misuse substances do not meet all DSM-5 criteria for an SUD. For example, tolerance is a key diagnostic criterion of an SUD. But because of the aging process, older adults have a lower tolerance for alcohol and other substances than younger people. Thus, although tolerance in an older person is still a sign of substance dependence, it looks different in older adults than in younger individuals.

Chapter 1 of this TIP provides information and statistics about overall substance misuse, misuse of specific substances, and effects of substance misuse among older adults. The following sections in this chapter of the TIP provide a brief summary of this information.

Alcohol Misuse

Older adults use alcohol more than any other substance.[974,975] In 2019, 52.8 percent of people ages 60 to 64 years and 43.9 percent of people 65 and older were estimated to have used alcohol in the past month,[976] and **3.4 percent of adults 50 and older had AUD.**[977]

Alcohol misuse differs between older men and older women. For example, women tend to feel the negative effects of alcohol after having fewer drinks than is the case for men.[978] They may be more vulnerable to the effects of alcohol misuse—a concerning fact, given that drinking rates (including for binge drinking) are increasing more rapidly among older women than older men.[979]

Misuse of Other Substances

Although most older adults do not use illicit substances, some do. For example, according to data from 2019,[980] SUDs involving illegal drugs occurred in approximately 390,000 adults ages 50 to 54; 271,000 adults ages 55 to 59; 282,000 adults ages 60 to 64; and 227,000 adults ages 65 and older.

Prescription medications are some of the most commonly misused substances among older adults in the United States. Prescription medication misuse involves taking a medication other than as prescribed, whether accidentally or on purpose. Some older adults use prescription medications to "get high," but many misuse prescription medications by mistake to address sleep problems, chronic pain, or anxiety. **Pain relievers are the most commonly misused prescription medication among older adults.**[981]

Exhibit 6.2 describes classes of prescription medication.

EXHIBIT 6.2. Understanding Classes of Medications

Most of your older clients will be taking at least one prescription medication. Many clients take more than one. Be sure you are familiar with the different types of medication classes. This will help you better understand the potential cognitive effects and drug–drug interactions related to the medications your clients are taking. Common medication classes include:[982]

- **Sedative-hypnotics,** which are often prescribed for sleep problems or anxiety. They include barbiturates (e.g., amobarbital, secobarbital) and benzodiazepines (e.g., lorazepam, alprazolam). Sometimes the term "tranquilizer" is used to describe antianxiety medications such as benzodiazepines.
- **Opioid analgesics,** which are prescribed to treat pain. Opioid analgesics work by attaching on opioid receptors in the brain. Examples include oxycodone and hydrocodone/acetaminophen.
- **Nonopioid analgesics,** which people take to control pain. But these pain medications do not act on opioid receptors in the brain. Examples include aspirin and acetaminophen.
- **Stimulants,** which help people feel alert or full of energy. Examples include amphetamine/dextroamphetamine and methylphenidate.

Between 11 and 18 percent of older adults, depending on age range, report using tobacco in the past month.[983] These numbers are troubling because, in adults ages 65 and older, smoking is associated with more than double the chances of binge drinking and triple the chances of illicit drug use or prescription medication misuse.[984]

The true population rate for benzodiazepine misuse by older adults is unknown. The American Geriatrics Society notes that although at times prescribing benzodiazepines to older adults may be appropriate, these medications may be potentially inappropriate for some older individuals. These medications increase the risk of falls and fractures, car accidents, problems with cognition, substance misuse and dependence, and death.[985,986]

It is unclear how many older adults use cannabis with a prescription, how many use it recreationally in areas where doing so is legal, and how many misuse it (whether through using recreationally in areas where it is illegal or by misusing prescription cannabis). **Cannabis may seem harmless, but in some older adults it may be linked to memory and thinking problems,** AUD and nicotine use disorder, and co-occurring mental disorders like depression, anxiety, bipolar disorder, and PTSD.[987,988]

Effects of Substance Misuse

Older adults are more likely than younger and middle-aged adults to feel the negative physical effects of medications, illicit drugs, and alcohol. In older people:[989]

- It takes longer for organs (e.g., liver, kidneys) to remove the alcohol and drugs from the body.
- With less lean body mass and total body water, older people can become intoxicated on even small amounts of a substance.
- The central nervous system is more sensitive to the effects of drugs and alcohol.
- Harmful drug–medication interactions are more likely. (See, for example, "Resource Alert: Preventing Dangerous Alcohol–Medication Interactions.") Older adults often take more than one medication. Harmful drug–medication interactions are associated with negative events such as:[990,991,992]
  - Injury (e.g., falls).
  - Breathing problems.
  - Sleeping problems.
  - Cognitive changes.
  - Seizures.
  - Internal bleeding.
  - Dangerous changes in blood pressure.
  - High or low blood sugar levels.
  - Overdose, which can be fatal.
  - Suicide and self-harm.
- Alcohol misuse can increase an older person's risk of injury, including those from:[993,994,995,996]
  - Falls.
  - Traumatic brain injury.
  - Car accidents.
  - Experiencing violence or abuse firsthand.
  - Suicide and nonsuicidal self-injury.
- Binge drinking on 5 or more days in the past month can increase the risk of certain physical conditions and mental disorders or make them worse. Such conditions include:[997,998,999,1000]
  - Depression.
  - Cancer.
  - Diabetes.
  - High blood pressure.
  - Heart failure.
  - Sleep difficulties.

RESOURCE ALERT: PREVENTING DANGEROUS ALCOHOL–MEDICATION INTERACTIONS

Older adults are at high risk for dangerous alcohol–medication interactions. Learn more about commonly used prescription and over-the-counter medications and how they interact with alcohol in the National Institute on Alcohol Abuse and Alcoholism's (NIAAA) publication *Harmful Interactions* (www.niaaa.nih.gov/publications/brochures-and-fact-sheets/harmful-interactions-mixing-alcohol-with-medicines).

Additionally, the Substance Abuse and Mental Health Services Administration (SAMHSA) publication *Get Connected: Linking Older Adults with Resources on Medication, Alcohol, and Mental Health* discusses the dangers of older adults misusing alcohol and prescription and over-the-counter drugs. It describes the signs of misuse and steps that older adults can take to prevent problems (https://store.samhsa.gov/product/SMA03-3824).

Links Between Substance Misuse and Cognitive Disorders

You will note that this section addresses the cognitive effects of alcohol misuse in far greater depth than it does the cognitive effects of other substance misuse. This is because most research on substance misuse and cognitive disorders focuses on alcohol. Research on the relationship between cognitive disorders and other substances, such as cocaine and cannabis, is still new, somewhat mixed, and inconclusive. This section does address benzodiazepines and tobacco, but in less detail.

The brain undergoes certain changes with age, like the shrinkage of white and gray matter tissue and decreased blood flow.[1001,1002] Because of these alterations, people sometimes experience changes in thinking as they age. Examples of normal age-related changes in thinking include:[1003]

- Having trouble recalling information without cues or reminders, such as not remembering what was on a shopping list when the list is not in front of the individual.
- Being unable to remember where a piece of information was heard or learned. Was it in the newspaper? Did someone mention it? Was it on television?
- Forgetting to perform activities, such as not remembering to turn off the kitchen light before going to bed.
- Having problems remembering the names of common objects.

Remember that aging differs across individuals, and whether someone experiences age-related changes in cognition depends on many factors.

Alcohol and Cognition

The link between alcohol use and problems with cognition in later life is complex. The effects of alcohol on a person's health are influenced by many factors, including how much and how often a person drinks, as well as by genetic and family-related factors. Social, cultural, and environmental factors can also affect a person's misuse of alcohol. These include such factors as:[1004]

- Exposure to alcohol consumption through television, movies, magazines, and social media.
- Experience of hardships related to immigration and cultural adjustment to life in the United States.
- Cultural norms related to drinking.
- Community environment, including level of violence, neighborhood housing conditions, and number of liquor stores in the community.

- Involvement with family, friends, or peers who misuse alcohol, raising the potential for misuse as a "learned behavior" adopted through attempts to imitate the drinking patterns of others.

Alcohol misuse is harmful to overall health[1005] and can increase the risk of dementia.[1006] It can also negatively affect certain areas of cognition, like memory.[1007,1008] **Drinking too much alcohol can damage the brain** (as well as the liver, heart, and other organs).[1009,1010] Older adults may be more likely than younger adults to experience harm to the brain and body caused by heavy drinking:[1011,1012]

- Heavy alcohol use can damage older adults' ability to:[1013,1014]
  - Learn new information.
  - Recall information.
  - Speak and understand language.
  - Solve problems.
  - Think and react quickly.
- Heavy alcohol use can lead to negative physical changes in the brain. For instance, too much alcohol can cause brain cells and tissues to shrink or no longer work as they should.[1015]
- Even lower levels of alcohol use can sometimes harm the brain of middle-aged and older adults,[1016] including areas of the brain that control memory.[1017]

What amount of alcohol harms a person's thinking? There is no one right answer. The amount that is harmful can differ from person to person. Alcohol can affect a person's cognition, no matter how little they drink. Clients need not have a problem with alcohol for it to have significant effects on their thinking. Do not make the mistake of thinking only people with AUD are at risk for cognitive problems like dementia and MCI.

Dementia and MCI

Does alcohol misuse cause or increase the risk of dementia or MCI? The answer is unclear, especially for Alzheimer's disease.[1018] Part of the problem is that different studies define terms such as "alcohol consumption," "light to moderate drinking," and "heavy or excessive drinking" differently.

Some studies have found a negative link between alcohol and cognitive disorders. For instance, research has found that:

- Heavy drinking can increase the risk of Alzheimer's disease.[1019]
- Heavy drinking, especially binge drinking, can increase risk of cognitive problems in later life.[1020,1021]
- Light-to-moderate drinking can increase the risk of MCI turning into dementia.[1022]
- Heavy drinking as a young adult can increase the risk of certain types of dementia later in life.[1023]
- Middle-aged adults who drink often (i.e., several times per month) may be more than twice as likely to have MCI in older adulthood as people who do not drink often (i.e., less than once per month). This risk appears to be even higher in people who have genes that increase their chances of developing Alzheimer's dementia (e.g., the APOE e4 gene).[1024]

What happens when people who already have dementia, MCI, or other problems with cognition drink alcohol? It depends on how much they drink and other individual factors. For instance, which if any medications are they taking? Are they at risk for dementia because of their genetic background? Consider the following:

- Heavy alcohol use can be toxic to the brain. People with dementia or MCI are already struggling with their thinking. Adding alcohol to the situation can potentially worsen their cognitive problems.
- Alcohol use can worsen dementia symptoms (e.g., lack of interest in people or activities).[1025]
- Clients with cognitive problems may forget how much they drank, raising risk for drinking too much.

What should you as a provider tell your older clients about alcohol misuse and their risk of cognitive problems? First, remember that definitions, methods, and research questions differ

among studies. This makes it difficult to know the true relationship between alcohol and risk of dementia or MCI. However, that does not mean that you should take this risk lightly.

Here are some important points you can make when discussing with older clients their risk of developing cognitive problems because of alcohol misuse:

- Heavy alcohol use damages the brain, heart, liver, and other organs.[1026,1027]
- Older people are more likely than younger people to feel alcohol's negative effects.[1028,1029] So even light or moderate drinking can be more harmful to the brain.
- Drinking habits and biological factors differ from person to person. For instance, people who drink wine may be at less risk from light-to-moderate drinking than people drinking other alcoholic beverages. People who do not have genes that elevate their risk for dementia (such as the e4 allele of the APOE gene) may be at less risk from light-to-moderate drinking than others who are at high genetic risk for dementia.[1030]

HOW MUCH ALCOHOL IS "HEALTHY"?

How "safe" or "healthy" is alcohol truly? A 2018 systematic analysis tried to answer this question by estimating the risk of alcohol consumption levels to health among people in 195 countries.[1031] The study authors found that alcohol contributed greatly to disability and deaths, owing to its connection to conditions such as:

- Tuberculosis.
- Cancer.
- Cardiovascular disease.
- Stroke.
- Diabetes.
- Accidental injuries.
- Self-harm.
- Interpersonal violence.

The study authors state that, based on their findings, any amount of alcohol use, even minimal, can lead to loss of health. Although they found some beneficial effects of alcohol consumption for heart disease and diabetes among women, these benefits were outweighed by the health risks, especially those of cancer, infectious diseases, and injuries.

"The widely held view of the health benefits of alcohol needs revising," the authors write. "Our results show that the safest level of drinking is none" (p. 1026).

The TIP consensus panel recommends that you counsel older clients on the possible dangers of alcohol misuse, especially heavy alcohol use and possible alcohol–medication interactions. If you screen a client for alcohol misuse, you should also screen him or her for cognitive impairment.

Delirium Tremens

People who drink heavily are at risk for a life-threatening condition called delirium tremens (or alcohol withdrawal delirium). Delirium tremens is different from delirium. **Delirium** is a cognitive disturbance in which people become confused and disoriented. Delirium can occur in older people who have recently undergone surgery or are taking multiple prescription medications, or who are experiencing common but serious medical conditions such as infections or dehydration.[1032,1033,1034]

Delirium tremens is a serious and potentially deadly consequence of alcohol withdrawal. In fact, it is the most serious adverse effect of alcohol withdrawal. **Symptoms of delirium tremens could be mistaken for signs of dementia.** Dangerous symptoms can include:[1035,1036]

- Hallucinations.
- Confusion (or disorientation).

- Rapid heart rate or high blood pressure.
- Sweating.
- Nausea or vomiting.
- Seizures and tremors.

Behavioral health service and healthcare providers should stay alert for symptoms of delirium tremens when treating older clients with alcohol withdrawal. About 3 to 5 percent of people hospitalized for alcohol withdrawal have delirium tremens.[1037] Without treatment, delirium tremens can be deadly because of serious complications like heart arrhythmias.[1038] Thus, it often requires treatment in intensive care.

Alcohol-Related Dementia

Long-term heavy drinking can directly cause alcohol-related dementia (ARD).[1039] ARD occurs in up to a quarter of older people with AUD and is more likely to be diagnosed in men.[1040] Little scientific evidence exists on the amount, length, and severity of alcohol use that leads to ARD.[1041] Some researchers believe that ARD develops because of a lack of vitamin B1 (thiamine)[1042] and the direct neurotoxic effects of ethanol.[1043] To confirm a diagnosis of ARD, refer the client to a neuropsychologist or neuropsychiatrist for indepth cognitive testing.

WERNICKE–KORSAKOFF SYNDROME

Wernicke–Korsakoff syndrome (WKS) includes both Wernicke's encephalopathy and Korsakoff syndrome—two brain disorders linked to lack of vitamin B1 (thiamine). Heavy alcohol use is often the cause of WKS, but physical conditions, such as cancer, can also cause it.[1044]

WKS is sometimes called **alcohol-induced persisting amnestic disorder.** Three main symptoms occur in WKS: problems with eye movement, confusion, and an inability to control muscle movements (also called ataxia), such as when walking. WKS is rare, occurring in about 1 percent of the general population. WKS is much more common in people with AUD, but prevalence rates vary widely.[1045]

In some ways, WKS is similar to ARD. Both appear to be caused in part by a lack of vitamin B1. Both conditions can improve after clients stop using alcohol, start taking vitamin B1, or both. People with WKS can have such behavioral symptoms as loss of interest in all activities (called apathy) and restlessness, mood symptoms (e.g., depression, anxiety), and psychotic symptoms (e.g., hallucinations, delusions).[1046] To confirm a diagnosis of WKS, you will need to refer the client to a neuropsychologist or neuropsychiatrist for cognitive testing.

Benzodiazepines and Cognition

Compared with older people who have never used benzodiazepines, older adults who have used them[1047] **(ever, recently, previously, or for long periods of time) appear to have a higher risk of dementia.** Older people with long-term use (i.e., greater than 3 months) of benzodiazepines may be 1.5 to 2 times more likely to develop dementia as people who have not used them long term.[1048] The risk of dementia with benzodiazepine use appears to grow as the dose of benzodiazepine increases.[1049]

Offer older clients who have taken benzodiazepines for a long time or have taken a high dose of these medications cognitive screening to assess problems in their thinking. (See Chapter 3 for cognitive screening measures.) **Assessment of memory and cognitive functioning should be part of the annual exam of all older adults.** High-dose or long-term use of benzodiazepines is an appropriate reason to perform cognitive screening, whether or not the older client asks for it, because older clients, especially those with cognitive impairment, may not realize that they need this screening.

The American Geriatrics Society cautions that benzodiazepines are potentially inappropriate in most older clients, but also notes that their use may be appropriate in certain limited circumstances, such as for seizure disorders.[1050] (See text box on the American Geriatrics Society 2019 Beers Criteria® for Potentially Inappropriate Medication Use in Older Adults.) **Consider whether older clients who take benzodiazepines need referral for a medication switch.** Cognition may improve following the switch to alternative medications or with a gradual reduction in dosage of these medications.

In addition to understanding the problems related to benzodiazepines, **determine whether there have been any changes or additions to the client's medications.**

Medications contraindicated or causing adverse reactions and complications may temporarily impair cognition or exacerbate existing MCI.

The American Geriatrics Society Beers Criteria® list medications that are potentially inappropriate for older adults because the risks often outweigh the benefits. At the time of this publication, the 2019 Beers Criteria® are the most recent.[1051] Clients taking medications in the brief list that follows (which is drawn from the full Beers Criteria®) should be referred to a healthcare provider to discuss possibly switching medications:

- Certain antidepressants (e.g., amitriptyline, nortriptyline)
- First-generation (older) and second-generation (atypical) antipsychotics
- Barbiturates (e.g., phenobarbital, secobarbital)
- Short-, intermediate-, and long-acting benzodiazepines (e.g., alprazolam, clonazepam)
- Certain pain medications (e.g., ibuprofen, naproxen)

The 2019 Beers Criteria® also newly recommend avoiding concurrent use of benzodiazepines and prescription opioids, while stating that concerns about interactions should be weighed against the need to treat chronic pain.

Note that the Beers Criteria® list medications that are **potentially** but not **definitely** inappropriate. For more on how to properly apply the recommendations, see this editorial in the *Journal of the American Geriatrics Society:* https://onlinelibrary.wiley.com/doi/epdf/10.1111/jgs.15766.

Tobacco and Cognition

A recent study found that people who currently smoke cigarettes were much more likely to have dementia (any type) than people who had never smoked.[1052] Interestingly, people who formerly smoked had the same risk of dementia as people who never smoked. **This means that stopping tobacco use could be powerful in reversing the risk of dementia.** Research findings from four large studies appear to confirm the harmful relationship between smoking and increased risk of dementia.[1053,1054,1055,1056] However, more research is needed to explore this relationship. That said, tobacco use is known to cause many serious negative health problems. You should counsel all clients who use tobacco to quit.

RESOURCE ALERT: GOING SMOKE FREE

For free support in helping your clients quit tobacco, call 1-800-QUIT-NOW (1-800-784-8669) and visit https://smokefree.gov.

For tips on quitting tobacco use from former smokers, direct your clients to this CDC webpage: www.cdc.gov/tobacco/campaign/tips/index.html.

Substance Misuse and Co-Occurring Mental Disorders That Affect Cognition

Some older adults who have mental disorders also misuse substances.[1057] For instance, in older adults, alcohol misuse often co-occurs with depression.[1058,1059] In older people, depression is associated with problems with reported memory, attention, problem-solving, and the ability to think and react quickly.[1060] According to data from the National Survey on Drug Use and Health, an estimated 1.7 million older adults (ages 50 and above) in the United States had a co-occurring mental disorder and SUD in 2019.[1061]

Treatment rates for older people with co-occurring conditions are low. Estimates from 2019 showed that just 9.6 percent of people 50 and older with any mental illness and a past-year SUD received substance misuse services at an SUD treatment facility as well as mental health services.[1062] One reason for the undertreatment of co-occurring disorders (CODs) in older adults is that **CODs tend to be overlooked and underdiagnosed.**[1063]

Older adults with CODs tend to use more behavioral health services than do older adults without CODs. Even so, they are at risk for negative health and psychosocial outcomes, including:[1064,1065]

- Thoughts of suicide and of death in general.
- Some medical issues (e.g., liver disease).
- Severe symptoms of depression.
- Being divorced, separated, or widowed.

Substance misuse often makes the symptoms of a co-occurring mental disorder worse and harder to treat. For example, substance misuse can worsen cognitive symptoms of co-occurring mental disorders. Just like substance misuse, mental disorders can lead to difficulties with cognition. Cognitive symptoms can make it harder for older adults to recognize their substance misuse,[1066] which could reduce likelihood of seeking SUD treatment.

Substance misuse, co-occurring mental disorders, and cognitive disorders are all related to one another. And they all have similar symptoms. If an older client has any one of these conditions, screen for all three. (Screening measures for these conditions appear in Chapter 3 of this TIP.) Major depressive disorder (MDD) and generalized anxiety disorder (GAD) often co-occur with substance misuse in older adults and negatively affect the brain. PTSD is less common in older people than MDD and GAD, but it does occur, especially in older military veterans. Be alert for these disorders in older clients who misuse substances and have cognitive difficulties.

MDD and Depressive Symptoms

MDD and depressive symptoms are both risk factors for and outcomes of substance misuse in older adults. In fact, MDD is one of the most commonly co-occurring mental disorders of older clients who misuse substances.[1067] A recent meta-analysis found that one in four people with dementia had clinically significant depressive symptoms.[1068] In a large sample of older adults with alcohol misuse, 29.7 percent reported having symptoms of depression.[1069] In this same study, rates of depression were especially high among older adults with two or more chronic health conditions (such as heart disease or diabetes). In these adults, alcohol misuse was five times more common in those with depression than in those without depression.

Whether MDD is a risk factor for dementia is unclear. It is also unknown whether having depression **and** substance misuse causes more cognitive problems than just having depression **or** substance misuse, but not both.[1070] Some research suggests that a relationship does exist between depression and cognitive disorders.[1071] For example:

- Adults with depression that starts earlier in life are at double the risk for dementia than adults who do not have depression.[1072]
- People with late-life depression are at a higher risk of certain types of dementia.[1073]

Depression is not a normal part of aging. Do not ignore even mild symptoms of depression in older clients.

- In one study, 70 percent of women ages 85 and older with depressive symptoms were diagnosed with MCI within 5 years, and 65 percent had dementia.[1074]
- Dementia risk seems higher in people with more frequent and severe depressive episodes.[1075]

Anxiety Disorders

About 10 to 15 percent of older adults meet criteria for an anxiety disorder.[1076,1077] Among the most common anxiety disorders in older people are GAD and specific phobias.[1078] In Wave 2 of the National Epidemiologic Survey on Alcohol and Related Conditions (NESARC), prevalence of any past-year anxiety disorder among adults ages 55 and older was 11.4 percent, that of GAD was 2.8 percent, and that of specific phobias was 5.8 percent.[1079]

Older adults with anxiety may be at an increased risk of substance misuse.[1080] Older adults living in the community, as well as those in SUD treatment, have higher rates of comorbid mental disorders, including anxiety, than older adults without substance misuse.[1081] In an analysis of data from Waves 1 and 2 of NESARC,[1082] older adults with a past-year SUD had a significantly greater chance of also having persistent anxiety compared with older adults without an SUD. The risk of substance misuse in older people with anxiety may be even higher for older women.[1083]

Anxiety symptoms in older adults can increase the risk of cognitive problems, especially with memory and learning.[1084] Anxiety disorders are also linked to other conditions that can affect cognition, including depression[1085] and substance misuse.[1086]

In a 2018 meta-analysis, the overall prevalence of clinically significant anxiety among people with dementia was 14 percent.[1087] Compared with depression, less is known about anxiety as a risk factor for dementia. Even so, the evidence shows:

- Among individuals newly diagnosed with dementia, about 31 percent previously had an anxiety diagnosis, compared with only 14 percent of older adults without dementia.[1088]
- An anxiety disorder almost triples the risk of dementia.[1089]
- People who have anxiety and depression are about 2.85 times more likely to have dementia.[1090]
- Anxiety appears to be a major predictor of cognitive problems in general and of dementia specifically.[1091] This may be especially true for many older adults (ages 80 and older).
- When older adults with anxiety have cognitive problems, these problems are often with memory, attention, and problem-solving abilities.[1092]

PTSD and Trauma

Older people are at risk for PTSD and substance misuse, although the rate of PTSD in older people is low. For instance, in Wave 2 of NESARC, 3.5 percent of adults ages 55 and older were reported to have past-year PTSD.[1093] In another study that also looked at Wave 2 data from the same survey, about 22 percent of adults ages 60 and older who met some but not all criteria for PTSD had an SUD, and 27 percent of older adults who met full criteria for PTSD had an SUD.[1094] Older adults who met at least some criteria for PTSD had 1.6 times greater chances of having an SUD than older adults who met no PTSD criteria.

It is unclear how common PTSD is in people with dementia. A meta-analysis examining rates of mental disorders among people with dementia noted a lack of research on PTSD specifically.[1095] Based on very limited studies, the authors estimated the overall prevalence of PTSD in dementia to be 4.4 percent.

Older adults who are military veterans also may be at risk for co-occurring PTSD and substance misuse. In a systematic literature review of studies about older veterans with PTSD, the prevalence of co-occurring SUDs ranged from about 1 percent to 11 percent.[1096]

Take the time to learn whether older clients who misuse substances also have a history of trauma or abuse. (Please refer to "Screening for PTSD, Trauma Symptoms, and Abuse" in Chapter 3 of this TIP for additional information.) **Also determine whether PTSD is present.** A trauma-informed approach to the screening, assessment, and care of older clients who misuse substances can help

put clients at ease. It will create a setting in which clients are more likely to open up and share with you the details of their trauma. You can take a trauma-informed approach by:[1097,1098]

- Making sure clients feel safe in your program—both physically and mentally.
- Using a gentle and warm attitude.
- Staying open and nonjudgmental. This builds trust among providers, staff members, clients, and family members.
- Working with your clients in a cooperative, shared way to make treatment decisions together. This helps empower clients and reminds them that they have a voice in the care process.
- Letting clients know that it is normal and healthy to express emotions, whether positive or negative. This is especially useful with older clients because older adults may be more likely to shy away from discussing negative feelings or traumas. They may be more likely to talk about physical symptoms rather than emotional ones or to dismiss traumas as "normal" parts of life.[1099]
- Being responsive to racial, ethnic, and gender disparities that may affect your clients' health. Realize that clients may have specific needs in these areas that can be addressed in the healing process.
- Offering peer support and referral to mutual-help programs. Working with someone who understands the lived experience of trauma and PTSD can be powerful for clients.
- Remembering to screen and assess clients for mental disorders and other conditions that co-occur with PTSD or trauma, such as depression and substance misuse.

How Providers Can Help

To help older adults with cognitive or co-occurring mental disorders related to substance misuse:

- **Educate older clients and their caregivers about the definitions and facts** on co-occurring mental disorders and cognitive problems related to substance misuse. This includes making sure clients and caregivers understand that the "safest" level of alcohol use is none at all. No amount of alcohol will be safe for older clients who take certain medications, have certain health conditions, or engage in certain activities (see Chapter 4).
- Screen older clients who misuse substances for co-occurring mental health conditions such as depression, anxiety, and PTSD.
- **Screen older clients who misuse substances (especially alcohol) for co-occurring cognitive impairment**. Older clients who take high doses of benzodiazepines or have been taking benzodiazepines long term also should be screened for cognitive problems.
- **Interview clients, caregivers, and practitioners** (with clients' permission) to determine whether changes in medications are leading to, or worsening, cognitive impairment.
- **Offer clients drug and alcohol counseling, mental health services, or both, as appropriate.** If your program does not offer these services, refer clients to a local program that does—and, if possible, to one that is experienced in working with older clients who misuse substances.
- **For clients who screen positive for cognitive problems, give referrals** for full cognitive assessments, which should include indepth cognitive testing. Only behavioral health service providers with specific training and experience can give these tests (a neuropsychologist or neuropsychiatrist).
- Offer resources and mental health services (or referrals for services) as needed to older clients who misuse substances, have cognitive disorders, or both; make such offers to their caregivers as well, if needed.

The U.S. Preventive Services Task Force recommends that healthcare providers screen for unhealthy alcohol use in adults ages 18 years or older and provide those who show 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).

Screening for CODs and Cognitive Disorders

Older clients in need of treatment or already in treatment for SUDs should be screened for disorders that co-occur with SUDs, such as depression, anxiety, and PTSD, as well as cognitive disorders.

Screening Instruments

This section discusses several screening measures for depression, anxiety, PTSD, trauma/abuse, and cognitive problems. Some age-appropriate measures appear in the Chapter 6 Appendix and the Chapter 3 Appendix.

Consider your scope of practice before delivering these instruments. You may need training before you can give certain ones to clients. This is especially true for cognitive measures. Make sure you understand how to administer each instrument properly, how to interpret the score, and what follow-up is needed based on the score. If no one in your program can help you get the training you need, refer the client to another behavioral health service or healthcare provider who can perform the screening.

Screening instrument for cognitive disorders

For a client who may have cognitive impairment, use the Mini-Cog©. See Chapter 3 for a description of and link to this instrument.

Screening instruments for depression

Screen older clients who misuse substances, have cognitive disorders, or both for depression. Depression commonly co-occurs in older people who misuse substances.[1100,1101] This TIP discusses two well-researched depression screeners approved for use in older clients:

- The Geriatric Depression Scale–Short Form (15 item).
- The nine-item Patient Health Questionnaire.

Screening instruments for anxiety

Older adults with anxiety are at increased risk for substance misuse, especially alcohol misuse and tobacco use.[1102] You can screen for anxiety using the:

- Geriatric Anxiety Scale.
- Penn State Worry Questionnaire.

These measures have been approved for use with older adults.[1103,1104]

Screening instruments for PTSD, trauma, and abuse

PTSD or a history of trauma or abuse can increase the odds that an older person will misuse substances.[1105] **In addition to asking older clients about their current and past history of trauma and abuse, use brief screening measures to further explore this area.** For instance, you can use the:

- PTSD Checklist for DSM-5.
- Primary Care PTSD Screen for DSM-5.

To screen for possible abuse, give the Elder Abuse Suspicion Index©.

Interventions for Substance Misuse and Co-Occurring Mental/Cognitive Disorders

Healthcare and behavioral health service providers have several options for helping older clients who misuse substances and have depression, anxiety, PTSD, or cognitive problems:

- **Educate clients about substance misuse,** its effects on older people, and what "safe" or "nonrisky" use means. For some older clients, education alone helps them end their substance misuse.
- **Provide drug and alcohol counseling to help clients reduce or stop their use of substances.** If your program cannot offer specialized addiction services, make a referral to another local program that can. (Learn more about AUD treatment and drug use disorder treatment for older adults in Chapters 4 and 5 of this TIP, respectively.)
- **Brief counseling approaches,** such as motivational interviewing, can help older adults reduce substance use.[1106] Brief approaches can be adapted to clients' level of cognitive impairment.[1107]

- Find out whether your client has an interest in **other nonmedication treatments, such as therapy that involves art, music, or animals.** Some research suggests that these "alternative" therapies can help people with dementia reduce their anxiety, restlessness, and apathy.[1108,1109,1110]
- **Help your clients live healthier lives**. A healthy lifestyle may help slow the rate at which cognitive problems get worse over time. For instance, you can:[1111,1112]
  - Encourage clients to **stay physically active** through light exercise (e.g., walking, yoga, stretching programs).
  - Remind clients that mental activity is just as important as physical activity. Offer them ways to **stay mentally active** through reading, using computers/the Internet, or doing crossword puzzles and other "brain games."
  - Offer behavioral techniques to help clients who are not getting enough **quality sleep** each night (like teaching good sleep hygiene and providing advice on reducing nighttime stimuli).[1113]
  - Encourage clients to **spend time socializing** with family, friends, and close others as well as develop social networks (for clients who do not already have or use them).
  - Teach clients the importance of a **healthy diet** that meets their nutritional needs. A healthy diet can improve other physical problems affecting cognition (e.g., high blood pressure, obesity).
  - Support clients' efforts to **reduce or stop substance use;** give information and interventions related to tobacco cessation.
  - Find out whether clients have **hobbies or interests** that remain enjoyable. If not, help them identify pleasant activities to try to improve their quality of life and lift their spirits.
- **Make referrals to healthcare providers** who can work with clients and their caregivers to decide whether medication treatment is needed. Medication treatment may be useful for certain types of SUDs, such as AUD, tobacco use disorder, and opioid use disorder. (See Chapters 4 and 5 for more information.) Medications may also be useful for cognitive problems. They cannot cure dementia, but they may be able to help reduce some of its symptoms.[1114]
- Be supportive and positive for your clients. One way to do this is by referring them to **peer recovery or mutual-help groups,** such as Seniors in Sobriety. (See "Chapter 6 Resources.") These groups can increase clients' chances of achieving long-term abstinence, plus help keep clients socially active. Keep on hand a list of local peer recovery support programs to present to clients.
- Supply informational materials in your program's waiting room and meeting rooms (e.g., bulletin board or display case flyers, brochures, handouts) and offer these resources to your clients.

Addressing Caregiver Concerns

Many people provide unpaid care to older adults with whom they have a personal relationship. These caregivers, typically significant others like family members, friends, and neighbors, provide a wide range of services and supports to older adults, including:[1115,1116]

- Help with ADLs, such as bathing, dressing, eating, toileting, and transferring (in and out of a wheelchair, for instance).
- Help with instrumental ADLs, such as transportation, housework, food preparation, shopping, using communication devices, and managing finances.
- Emotional and spiritual support.
- Financial help.
- Shared housing.
- Help with communication and advocacy with service providers.
- Help with navigating service systems.
- Help with decision making related to healthcare and financial matters.
- Monitoring of health problems.
- Medication administration and monitoring.
- Medical/nursing tasks, like injections, tube feeding, and care of catheters, colostomies, and wounds.

Caregivers may carry out these activities intermittently, part time, or full time, including from a distance.

The physical, mental, emotional, and financial challenges of these caregiving responsibilities can result in "caregiver burden."[1117] Caregiving for older adults who misuse substances, have cognitive disorders, or both can be very stressful. This stress can make it hard for caregivers to function well at work, maintain social relationships, and take care of themselves.[1118]

Behavioral health service, healthcare, and social service providers need to be alert for caregiver stress. Stress can negatively affect the quality of attention the caregiver gives to your client. For instance, caregiver stress has been linked to a higher risk of elder abuse.[1119] Also, caregiver stress is associated with higher mortality.[1120] And caregivers may themselves be at risk for developing chronic health conditions such as high blood pressure, heart disease, and back pain.[1121] Caregiver stress may even lead to caregiver substance misuse. Caregivers who feel high levels of stress may need behavioral health services to build better coping skills, access resources, address their concerns, and improve their mood.

Caregivers may not tell you outright that they are feeling stressed or frustrated. Make a point to **ask caregivers directly about any difficulties they are having, including mental and physical symptoms. Here are some examples of questions you can ask** to help caregivers open up:

- "I know caring for your wife must be very difficult. How are you holding up?"
- "What do you do for fun or to 'let off steam'?"
- "Who do you turn to when you need support?"
- "Have you spoken with other caregivers who care for someone with dementia? Many caregivers find it very helpful to talk to someone who really 'gets it.' May I give you some information about local caregiver support groups?"
- "Are you familiar with Al-Anon? Many adult children of people with alcohol addiction find their meetings useful. Would you like me to give you their contact information?"

Helping Caregivers of Clients Who Misuse Substances

Caregivers may not always see the alcohol or drug use as a problem. They may feel guilty asking the person to stop using. Comments like the following are not unusual:

- "My George has had a beer after work every night for 40 years. I'm not telling him to stop now."
- "It's none of my business if she has a couple of glasses of wine. At her age, what's the harm, really?"
- "I feel bad asking my brother to stop smoking. His cigars are his one last pleasure in life."

Many caregivers may think that substance use is harmless. But for aging adults, that is not necessarily true. You can help caregivers by:

- **Sharing facts about alcohol or drug use in older adults** and the importance of avoiding illicit drugs, prescription medication misuse, and harmful drug–drug interactions.
- **Teaching them new coping skills** and offering interventions. This could include:
  - **Helping caregivers share their feelings of stress or concern with your older clients.** Talking to older adults about their substance misuse can be hard. You can help caregivers learn how to express their thoughts and feelings in a way that is healthy and helpful.
  - **Teaching caregivers better ways to handle your older clients' upsetting behaviors.** Some older adults who misuse substances can "act out," become angry, or behave in ways that are stressful to caregivers. Teach caregivers how to better manage these intense emotions and behaviors.
  - **Offering caregivers mental health services or referral to treatment.**
- **Helping them find peer recovery support groups** (e.g., caregiver support groups).
- **Encouraging them to join support groups.** Refer them to local mutual-help groups for family members of people who misuse substances, like Al-Anon and Adult Children of Alcoholics.

Helping Caregivers of Clients With Dementia

Caring for individuals with dementia can have negative psychosocial and physical effects. For example, such caregiving can negatively affect sleep, blood pressure, mood, and social functioning.[1122]

A caregiver may use alcohol or benzodiazepines to try to control an older adult's behavior. For instance, a caregiver may give alcohol to help the older adult sleep or to calm down the older adult when he or she is upset and angry. This is not recommended, is unsafe, and can worsen these behaviors. Tell caregivers not to use alcohol or benzodiazepines in this way.

Supports for people caring for older adults with dementia can include:[1123,1124,1125]

- Education-based programs to help caregivers:
  - Learn about the disease.
  - See the importance of taking care of themselves and reducing their own stress.
  - Better handle the older adults' negative behaviors (e.g., acting "out of control").
- Psychosocial services that provide:
  - Stress management techniques.
  - Relaxation skills.
  - Positive thinking strategies.
  - Tips on proper self-care (e.g., healthy eating, sound sleeping).
  - Chances for caregivers to share frustration, fear, sadness, and other negative feelings.
  - Problem-solving and other coping techniques.
- Participation in caregiver support groups—especially ones that focus on caregiving for someone with dementia. These groups let caregivers share common experiences and learn from one another; for instance, the Alzheimer's Association offers caregiver support groups (www.alz.org/events/event_search?etid=2&cid=0).

Helping Caregivers of Clients With Both Substance Misuse and Dementia

Anecdotal reports give some indication of the needs and problems faced by people caring for older adults with both substance misuse and dementia. **These caregivers likely face significant stressors. Greater levels of caregiver burden are present in caregivers of older adults with alcohol misuse who also have certain behavioral symptoms common in dementia**—disinhibition (or "out of control" behavior) and irritability—compared with caregivers of older adults with those same behavioral symptoms but no alcohol misuse.[1126]

Research about the burden of caring for people with multiple, complex, chronic conditions is also telling. For instance, having more than one chronic illness is linked to:[1127]

- Being highly dependent on a caregiver.
- A higher risk of death.
- More time spent in the hospital.
- Poor quality of life.
- Greater healthcare costs.

A caregiver of an older adult with co-occurring substance use and mental disorders may have unique challenges and special needs beyond those of caregivers of people with mental disorders only, including:[1128]

- Feeling unable to leave the older adult alone.
- Being more likely to fear the older adult will hurt himself or herself or others.
- Feeling less close to the older adult.
- Having more problems getting the older adult to take medications.
- Having more problems finding treatment.
- Feeling a higher level of emotional stress related to caregiving.
- Feeling that caregiving threatens his or her health.
- Feeling lonely as a caregiver.
- Having trouble talking with others about the older adult's mental health needs.
- Wanting help from a care coordinator or care manager.
- Wanting legal assistance.

Because of these concerns, caregivers for clients such as these may be especially in need of your help and resources. Be sure to reach out to them!

Summary

Substance misuse in older adults can increase the chances of having cognitive problems. It also can increase the chances of having co-occurring mental disorders with symptoms similar to cognitive disorders or mental disorders that cause changes in cognition and could be mistaken for a cognitive disorder. These co-occurring mental disorders include depression, anxiety, and PTSD. Behavioral health service and healthcare providers need to be aware of these other conditions and use screening instruments wisely to ensure that all older adult clients receive the right diagnosis and timely treatment. Treatments can address clients' and caregivers' mood, cognition, and functioning. Positive changes through treatment are possible for older adults who are dealing with substance misuse, mental disorders, and cognitive decline.

Chapter 6 Resources

Behavioral Health Service Provider Resources

Alcohol Misuse

SAMHSA—*A Guide to Preventing Older Adult Alcohol and Psychoactive Medication Misuse/Abuse: Screening and Brief Interventions* (www.ncoa.org/wp-content/uploads/SBIRT-Older-Adult-Manual-Final.pdf): This manual is designed to help providers implement an early prevention intervention program for older adults who are at risk for misusing alcohol or psychoactive medication.

SAMHSA—*Get Connected: Linking Older Adults With Resources on Medication, Alcohol, and Mental Health* (https://store.samhsa.gov/product/Get-Connected-Linking-Older-Adults-with-Resources-on-Medication-Alcohol-and-Mental-Health-2019-Edition/SMA03-3824): This toolkit will help providers learn—and educate clients—about alcohol and prescription medication misuse and mental health issues among older adults.

Dementia

Alzheimer's Association—Dementia Care Practice Recommendations (www.alz.org/professionals/professional-providers/dementia_care_practice_recommendations): These recommendations provide guidance to healthcare and social service providers who work with individuals living with dementia in residential and community-based care settings.

Association for Frontotemporal Degeneration—For Health Professionals (www.theaftd.org/for-health-professionals/): This webpage provides resources on diagnosing and treating frontotemporal degeneration, as well as links to webinars and clinical presentations.

National Alzheimer's and Dementia Resource Center (https://nadrc.acl.gov): Visitors to this website can access reports, toolkits, assessment tools, and webinars and other training materials.

National Institute on Aging (NIA)—Alzheimer's and Dementia Resources for Professionals (www.nia.nih.gov/health/alzheimers-dementia-resources-for-professionals): This webpage offers clinical practice tools, training materials, and other resources for healthcare and behavioral health service providers.

Registered Nurses' Association of Ontario—*Delirium, Dementia, and Depression in Older Adults: Assessment and Care* (https://rnao.ca/sites/rnao-ca/files/Delirium_dementia_and_depression_in_older_adults_LTC_case_study_and_discussion_guide.pdf): This publication contains a case study and a discussion guide to help providers learn the differences between depression, delirium, and dementia in older adults.

Client and Caregiver Resources

General Resources

Administration on Aging—Eldercare Locator (https://eldercare.acl.gov/Public/Index.aspx): This locator connects users to local services for older adults and their families.

ElderLawAnswers (www.elderlawanswers.com): This website maintains resources on financial and legal services related to caring for an older adult with healthcare and other needs.

Family Caregiver Alliance (www.caregiver.org): This organization offers an information line for caregivers of adults with chronic medical illnesses living at home, online caregiver support groups, and an online Family Care Navigator that provides a state-by-state list of services and assistance for caregivers.

mmLearn.org—Caregiver Training Videos (https://training.mmlearn.org/caregiver-training-videos): mmLearn has a library of free videos for healthcare, pastoral, and family member caregivers of older adults. Videos are available on specific topics, including caring for adults with dementia (https://training.mmlearn.org/caregiver-training-videos/topic/dementia).

National Alliance for Caregiving (www.caregiving.org): This organization conducts research and policy analysis, develops national best-practice programs, coordinates state and local caregiving coalitions, and provides a website offering educational resources for family caregivers.

Alcohol Misuse

Adult Children of Alcoholics (https://adultchildren.org): Adult children of people with AUD can use this website to find a listing of in-person and electronic meetings.

Al-Anon (https://al-anon.org): Al-Anon is a national mutual-help organization for people concerned about or affected by someone with alcohol misuse. The website offers information about the organization and how to find a local or electronic meeting.

NIA—Facts About Aging and Alcohol (www.nia.nih.gov/health/facts-about-aging-and-alcohol): NIA offers information about how alcohol can affect older adults' health and safety.

NIA—*Older Adults and Alcohol* (https://order.nia.nih.gov/sites/default/files/2018-01/older-adults-and-alcohol.pdf): Older adults can use this guide to learn about alcohol's harmful effects and ways to get help for alcohol misuse.

NIAAA—*Harmful Interactions* (www.niaaa.nih.gov/publications/brochures-and-fact-sheets/harmful-interactions-mixing-alcohol-with-medicines): Older adults and their caregivers can use this consumer guide to learn about harmful medication–medication and medication–alcohol interactions.

Seniors in Sobriety (www.seniorsinsobriety.com): This mutual-help organization for older adults with alcohol misuse has information about local meetings on its website.

Tobacco Use

CDC—Tips From Former Smokers (www.cdc.gov/tobacco/campaign/tips/index.html): Through this campaign, CDC offers videos of tips and stories from former smokers, plus other resources to help with tobacco cessation.

National Cancer Institute—*Clear Horizons: A Quit-Smoking Guide for People 50 and Older* (https://smokefree.gov/sites/default/files/pdf/clear-horizons-accessible.pdf): People ages 50 and older interested in tobacco cessation will find helpful information and strategies in this guide.

NIA—Quitting Smoking for Older Adults (www.nia.nih.gov/health/quitting-smoking-older-adults): This webpage provides information about nicotine and nicotine delivery devices (e.g., e-cigarettes, hookahs) and about strategies for stopping tobacco use.

Dementia

Alzheimer's Association—Resources (www.alz.org/help-support/resources): This webpage has links to a collection of consumer resources on Alzheimer's disease and dementia, including online tools, locators for community services and Alzheimer's Association chapters, and a virtual library.

Alzheimer's Association—Support Groups (www.alz.org/care/alzheimers-dementia-support-groups.asp): Local and online support groups offered by the Alzheimer's Association for caregivers and individuals with Alzheimer's can be found through this webpage.

NIA—Alzheimer's Disease & Related Dementias (www.nia.nih.gov/health/alzheimers): This webpage provides information about Alzheimer's causes, symptoms, and treatments, and about living with the illness or providing caregiving to someone who does.

NIA—Vascular Dementia and Vascular Cognitive Impairment: A Resource List (www.nia.nih.gov/health/vascular-dementia-and-vascular-cognitive-impairment-resource-list): This webpage links to free resources about vascular dementia, CADASIL (a rare form of vascular dementia), and Binswanger's Disease.

Chapter 6 Appendix

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 to 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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Continued		
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.[1129]

Clients with a GDS score of 6 or higher need further assessment and may need treatment for MDD.[1130] Clients with a GDS score below 6 should be screened again in 1 month if symptoms of depression are still present.[1131] If a client's depressive symptoms are no longer present in 1 month, give the depression screener again in 6 months.[1132]

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
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

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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
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
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

Reprinted from material in the public domain.[1133] *A digital, fillable form is available online (www.ptsd.va.gov/professional/assessment/documents/PCL5_Standard_form.PDF).*

Chapter 7—Social Support and Other Wellness Strategies for Older Adults

KEY MESSAGES

- Strong social networks support older adults in achieving and maintaining recovery from substance misuse. Providers can help older adults develop and maintain a social network that promotes recovery and wellness.
- Older adults have to increase their health literacy to maintain recovery and prevent relapse.
- Providers need to engage older adults in illness management and relapse prevention activities specific to substance misuse with a focus on health and wellness.
- Providers can help older adults feel more empowered by understanding the normal developmental challenges of aging and age-specific strategies for promoting resilience and setting goals.

Chapter 7 of this Treatment Improvement Protocol (TIP) will most benefit healthcare, behavioral health service, and social service providers who work with older adults (physicians, nurse practitioners, physician assistants, nurses, social workers, psychologists, psychiatrists, mental health counselors, alcohol and drug counselors, and peer recovery support specialists). It explains how older adults who misuse substances can benefit from wellness strategies that support relapse prevention, ongoing recovery, and better overall health. The keys to wellness for this group are having strong social networks and participating in health and wellness activities that support recovery.

The high prevalence of isolation in older adults who misuse substances can negatively affect cognitive functioning and reduce well-being. Older adults who lack family ties or social networks may find maintaining recovery from substance misuse difficult. Healthcare, behavioral health service, and social service providers can help older adults who misuse substances reduce isolation and improve recovery outcomes by promoting broader social networks.

Maintaining recovery from substance use can be harder for older adults who have trouble understanding and using health information. It may also be more difficult for those with limited self-management skills (e.g., difficulty engaging in regular exercise, healthy eating, or medication adherence). Medical conditions common in later life can also reduce functioning. Providers can engage older clients in skill-building and wellness activities that will support resilience and overall health while also reducing the likelihood of a return to substance misuse.

Organization of Chapter 7 of This TIP

Chapter 7 addresses promoting social support and other health and wellness strategies relevant to older adults in recovery from substance misuse.

The first section of Chapter 7 describes the importance of social support in promoting and maintaining health, wellness, and recovery among older adults who misuse substances. Types of positive social support, the impact of social isolation on health and wellness, and strategies for promoting and maintaining social support are examined.

The second section addresses how to promote other wellness strategies for older adults. This section specifically focuses on assessing and promoting health and wellness for older adults in recovery. It addresses health and wellness activities relevant to older adults, strategies for promoting health and wellness, illness self-management and relapse prevention approaches, and strategies for promoting resilience and empowerment among older adults, including goal setting.

The final section identifies targeted resources to support your practice, some of which appear in full in the Chapter 7 Appendix; additional resources appear in Chapter 9 of this TIP. Exhibit 7.1 provides definitions for key terms that appear in Chapter 7.

EXHIBIT 7.1. Key Terms

- **Addiction*:** The most severe form of substance use disorder (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).
- **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.[1134] 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.
- **Health literacy:** The ability to understand and use health information to make informed choices about health, wellness, and recovery.
- **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).
- **Mutual-help groups:** Groups of people who work together on obtaining and maintaining recovery. Unlike peer support (e.g., the use of recovery coaches or peer recovery support specialists), mutual-help groups consist entirely of people who volunteer their time and typically have no official connection to treatment programs. Most are self-supporting. Although 12-Step groups such as Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) are the most widespread and well researched type of mutual-help groups, other groups may be available in some areas. They range from groups affiliated with a religion or church (e.g., Celebrate Recovery, Millati Islami) to purely secular groups (e.g., SMART [Self-Management and Recovery Training] Recovery, Women for Sobriety).
- **Peer recovery support specialist:** Someone in recovery who has lived experience in addiction plus skills learned in formal training. Peer recovery support specialists may be paid professionals or volunteers. They are distinguished from members of mutual-help groups because they maintain contact with treatment staff. They offer experiential knowledge that treatment staff often lack.
- **Peer support:** The use of peer recovery support specialists (e.g., someone in recovery who has lived experience in addiction plus skills learned in formal training) to provide nonclinical (i.e., not requiring training in diagnosis or treatment) recovery support services to individuals in recovery from addiction and to their families.

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- **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).[1135] Remission is an essential element of recovery.
- **Resilience:** The ability to rebound from adversity, skillfully address age-specific developmental tasks, and respond creatively to stress and grow from those experiences.
- **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,[1136] SUDs are characterized by clinically significant impairments in health and social function and 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).

Social Support: The Key to Health, Wellness, and Recovery

People with significant social support tend to have healthier lifestyles, engage in fewer behaviors that risk health (e.g., substance misuse), and be more active. Older adults in long-term recovery from substance misuse have better outcomes when their social supports promote abstinence.[1137,1138]

Three major components of positive support for older adults are:

- **Family and friends.** Family members often provide most of an older adult's basic social support. Strong friendships and neighborhood supports can also be important to older adults. Friends often provide emotional support, and neighbors can offer immediate help in an emergency.

- **Mutual-help groups.** Mutual-help groups such as AA and NA can support abstinence and foster new social connections, a sense of belonging, and healthy lifestyles.
- **Religious or spiritual supports.** Participation in religious or spiritual fellowships can decrease social isolation and is associated with health and wellness.[1139]

In the 2015 World Values Survey, more than 75 percent of adults in the United States over age 60 responded that they considered themselves to be religious and sometimes or often contemplated the meaning of life (an indicator of a spiritual focus).[1140]

Many religions discourage drug use and alcohol use or misuse.[1141,1142] Involvement in religious and spiritual organizations can give older adults a sense of meaning, optimism, and self-esteem, lessening the impact of stressful life events like the death of a significant other.[1143] A sense of meaning and optimism can help maintain recovery from substance misuse.

The quality and diversity of older adults' social networks matter more than size in promoting health, well-being, and recovery and in lowering risk of substance misuse.[1144,1145] For example, tense relationships with family members can increase stress, which can negatively affect older adults' health and avoidance of relapse. In addition, too much support from children, although well-meaning, may increase older adults' dependence and reduce their sense of self-efficacy and well-being. Conversely, work colleagues, social contacts at senior centers, and behavioral health service and healthcare providers can be additional sources of emotional support. Mutual-help groups such as AA and NA can provide older adults with a stable source of friendships and enhance the diversity of their social networks.

The consensus panel recommends that you assess the number of social connections older adults have and also gauge the quality and diversity of those connections and how they promote wellness and recovery. (See the Chapter 7 Appendix for the Social Network Map for assessing and discussing social networks with older adults.)

Social Isolation

Social isolation, linked to loneliness, is common in older adults. Their social networks narrow because of retirement, decreased physical functioning, and deaths of spouses, intimate partners, and friends.[1146] A spouse or intimate partner is essential for many older adults' well-being. The death of a spouse puts older adults at high risk for social isolation, and may decrease life expectancy for men.[1147] Loneliness is linked with substance misuse in some older women.[1148]

ADDRESSING GRIEF

Older adults may experience multiple losses in a short time. Grief is a highly individualized experience; coping strategies need to be flexible and adaptive as you help clients explore feelings of grief.

Grief has no set timeframe. People do not "get over" the death of a loved one. Daily life continues as people integrate the experience of loss into their lived experience. As integration happens, the disorientation and disruption initially experienced after a death subsides, and older adults can open up to new possibilities.[1149]

You can provide a safe and supportive environment for clients to explore their feelings, help them remember their loved one, offer information about the grief process, identify struggles with coping, encourage them to tap into their own strengths and wisdom, and help them integrate the loss.[1150] If clients experience prolonged or complicated grief that interferes substantially with daily functioning—or if they have persistent suicidal ideation—consider referral to psychiatric evaluation or to a trained grief counselor.

Other factors that can add to social isolation for older adults include family members living far away, lack of transportation, cognitive decline, living alone or in unsafe neighborhoods,[1151] poverty, physical disability,[1152] and disruption of existing social networks via relocation to long-term care facilities.

Social isolation in older adults has been linked to:

- Increased likelihood of engaging in risky behaviors such as alcohol misuse and smoking.[1153]
- Increased risk of depression.[1154]
- Cognitive decline and risk for developing dementia.[1155]
- Poor overall health, cardiovascular disease, high blood pressure, sleep disturbances, and sedentary lifestyles.[1156,1157]
- Impairment in executive functioning, which makes it hard to engage in health-promoting physical activities[1158] or follow a relapse prevention plan.
- Increased risk for falls, rehospitalization, and death from all causes, including suicide among men.[1159]

SOCIAL ISOLATION AMONG OLDER ADULTS IN METHADONE MAINTENANCE TREATMENT

Older adults with opioid use disorder (OUD) who are in methadone maintenance treatment (MMT) may experience even more social isolation than older adults with other types of SUDs. Older adults who have used opioids for many years may have severed ties with family and friends and lost friends who overdosed. People who are in MMT also tend to be secretive about their history of opioid use and their status in treatment because of negative attitudes of friends, family, and society. Recent evidence suggests that people with a history of OUD tend to self-isolate because of:[1160]

- Past experiences of being taken advantage of.
- Fear of future loss.
- Desire to avoid depression/grief at death of friends/family.
- Past experiences of domestic violence.

You may need to address these concerns before you can work collaboratively with clients to build a nonusing social network that supports MMT as a pathway of recovery for older adults.

The consensus panel recommends that you screen older adults for social isolation and help them learn about the link between social isolation and substance misuse as part of your efforts to educate clients on health literacy. (See the Chapter 7 Appendix for a discussion of the Lubben Social Network Scale, a social isolation screening tool for older adults.)

Promoting Social Support for Older Adults

A lifespan perspective suggests that social networks change over a person's lifetime. One of the unique aspects of older adults' social networks is that those networks naturally shrink as people age and their close family members and friends die. This shrinkage may also occur because older adults become increasingly aware of the limits of time left in life and choose to focus on the most rewarding relationships. Doing so may help them emphasize emotional support while deemphasizing less satisfying relationships.[1161] A high degree of emotional closeness is associated with high levels of quality of life and well-being for older adults.[1162]

Strategies for improving social support for older adults in recovery from substance misuse should focus on expanding network size, increasing network diversity, and deepening the emotional closeness of network connections. Interventions to decrease social isolation and improve well-being should be adaptable to older adults' needs and interests, include their input about what works for them, and actively versus passively engage them (e.g., playing cards with friends versus watching TV together).[1163]

The consensus panel recommends the following interventions to promote social support for older adults who misuse substances.

Engage family members and other caregivers in recovery support. Perhaps the most important social support for older adults is frequent contact with family members (or other caregivers) who support their recovery. Help foster positive social contact between family members and older adults who misuse substances by:

- Involving family members and other caregivers in older adults' treatment (with express consent from clients).
- Educating clients, caregivers, and families about the importance of emotional and instrumental support for older adults' recovery. (An example of instrumental support is providing rides to appointments.)
- Educating caregivers about skillful ways to provide support.
- Educating family members about the importance of visiting the older adult when he or she is not misusing substances, rather than visiting only during substance-related crises (e.g., binge episodes).
- Recommending that family members and other caregivers participate in family support groups for caregivers and mutual-help groups for family members such as Al-Anon.

When family members are not nearby geographically or older adults are homebound, explore the possibility of clients' connecting with family members regularly via phone or video calling services. Studies show that frequent contact between older adults and family members via online communication applications decreases loneliness and increases social contact for the older adults.[1164]

See Chapter 4 of this TIP for more information about family and caregiver involvement.

Enlist neighborhood supports. Social cohesion in neighborhoods is another factor that promotes the health and well-being of older adults. For example, when neighbors provide instrumental support for older men and emotional support for older women, the older adults attain better physical health and mental well-being.[1165] You can help older adults build up this support by:

- Asking which neighbors they are close to.
- Helping them identify which neighbors have provided which kinds of support to them in the past.
- Asking them which neighbors they think would be supportive of their recovery efforts.

Many communities have befriending programs that send "friendly visitors"—who are trained volunteers—to the homes of older adults who have no close ties to neighbors or nearby relatives, or who are homebound. Visitors spend an hour or two a week with older adults to provide companionship, friendship, and linkage to health and wellness resources. They can often identify signs of substance misuse in the older adults they visit and help link these older adults to treatment resources. Contact your local Area Agency on Aging (AAA; see Resource Alert) to find out whether it or another organization in your community has a friendly visitor program.

RESOURCE ALERT: AREA AGENCIES ON AGING

AAAs' mission is to help older adults age with independence and dignity at home and in the community through a coordinated system of services and supports (https://eldercare.acl.gov/Public/About/Aging_Network/AAA.aspx). Established by the Older Americans Act (OAA) in 1973, AAAs now number 622 nationwide. The OAA was amended in 1978 to include services to American Indians, Alaska Natives, and Native Hawaiians.

Each AAA provides core services that address nutrition, disease prevention, health promotion, caregiver services, and older adult rights. Many AAAs also provide Medicare counseling, transportation, fall prevention and gentle exercise classes, adult daycare programs, social/recreational classes and groups, and other services geared to local community needs. AAAs are also a great place for older adults to volunteer.

Many states have Aging and Disability Resource Centers, often associated with AAAs, which can also provide specific community resources for services and supports to older adults and individuals with disabilities.

Go to https://eldercare.acl.gov and put in your ZIP Code to find the AAA in your community.

In rare cases, friends and family members may commit elder abuse.[1166] If you think such mistreatment is occurring, screen your older client for elder abuse (see Chapter 3 of this TIP).

Link clients to social and behavioral health support groups. In addition to linking your older clients to mutual-help groups such as AA, NA, or SMART Recovery, which can provide social as well as recovery support, refer them to social and behavioral health support groups in the community. These can range from smoking cessation groups to walking clubs to depression support groups. Create a list of organizations that offer support groups for older adults and actively link your client to one or more groups that are appropriate, accessible, and acceptable to him or her. (See Chapter 4 of this TIP for more information on active linkage to community resources and referral management.)

Agencies and organizations with support groups that may be helpful to older adults include:

- Recovery support organizations.
- Senior centers.
- Adult day health services.
- Community and private hospitals.
- Healthcare, behavioral health service, and social service programs for older adults.
- Veterans programs.
- Coalitions and advocacy groups for older adults.
- Assisted living facilities.
- Faith-based organizations.
- Community centers.

Link clients to peer recovery support specialists. An important strategy for increasing social support for older adults in recovery is to link them to peer recovery support services.[1167,1168,1169] Peer recovery support specialists work in a variety of settings, including addiction treatment programs, faith-based institutions, and recovery community organizations (RCOs).[1170] (For information on RCOs, see www.recoveryanswers.org/resource/recovery-community-centers.)

Peer recovery support specialists offer four types of social support: emotional, instrumental, informational, and affiliational (i.e., facilitating contact with others to strengthen social networks).[1171]

Linking older adults to peer recovery support specialists can:

- Increase and diversify older adults' social networks.
- Introduce older adults to the culture of recovery.
- Facilitate engagement and active participation in community-based mutual-help groups.
- Prevent relapse by helping older adults stay connected to mutual-help groups.

Peer recovery support specialists who work with older adults should have age-specific training and a commitment to working with this age group. These specialists are often older adults who can share their own experiences with recovery at this stage of life.

See Chapter 2 of this TIP for more information on key strategies for providing support to older adults.

Educate clients about social media and online social networking support. Online technologies—including social media applications and social networking websites—may be an important way for older adults to expand their support networks. Videoconferencing and use of social networking, educational and informational websites, and online discussion forums can reduce social isolation and improve social support, self-efficacy, and empowerment among older adults.[1172] In addition, information exchange about specific issues—such as substance misuse, recovery resources, chronic illness management, and health and wellness resources—in online social networks and discussion forums can boost well-being for older adults.[1173] Many addiction-focused mutual-help groups offer online meetings through chat rooms, web-based forums, and telephone or videoconferencing applications.

Many baby boomers already use smartphones and online technologies. About 42 percent of adults ages 65 and older own smartphones, up from 18 percent in 2013; 67 percent use the Internet.[1174] However, **barriers to social media and mobile technology use** include:[1175,1176,1177]

- **The cost** of owning a computer, tablet, or cell phone and data or Internet access fees.
- Lack of broadband infrastructure in rural and tribal areas.
- **Concerns about privacy** and what happens to personal information once it is posted on the web.
- **Decline in cognitive and physical functioning,** which hinders use. For instance, older adults may have physical or cognitive barriers in reading webpages that do not have universal accessibility, or difficulties using features of the device, like buttons on a cell phone or touchscreens.

Help older clients who are curious about or interested in trying online technologies for social support:

- **Access basic information about using online technologies safely** (e.g., protecting personal information, avoiding scams; for more information, see the Substance Abuse and Mental Health Services Administration's [SAMHSA] TIP 60, *Using Technology-Based Therapeutic Tools in Behavioral Health Services*).
- **Problem-solve ways to overcome access barriers** (Chapter 4 offers problem-solving strategies).
- **Learn about local and online resources** that are appropriate and acceptable to them. For example, senior centers, libraries, community colleges, community centers, AARP, Senior.net learning centers, and adult learning programs are potential sources of free or low-cost educational programs to help older adults learn how to use a computer and social media websites and applications.
- **Ask for support from family members or tech-savvy friends** who can help set up a computer, tablet, or cell phone; teach them how to safely use social media and other apps; and provide ongoing support in their use of technologies.

Specific websites offering assistance with social media are listed in the folllowing Resource Alert.

RESOURCE ALERT: CONNECTING OLDER ADULTS WITH SOCIAL MEDIA SUPPORTS

The *Staying Connected: Technology Options for Older Adults* brochure from Eldercare Locator (https://eldercare.acl.gov/Public/Resources/Brochures/docs/N4A_Tech_Brochure_P06_high.pdf) introduces older adults to types of social media and their benefits. It includes basic information on how to set up a Facebook account and how to use free video calling services like Skype.

Lifeline Support (www.lifelinesupport.org) provides information about a Federal Communications Commission program that offers eligible individuals financial assistance for Internet or cell phone services.

Some older adults living in retirement communities or long-term care facilities have a built-in social network that facilitates drinking.[1178] Older adults in such settings may perceive drinking as a pleasurable or necessary aspect of socializing with their fellow residents. If you have older clients who misuse alcohol to fit in to their residential setting, help them learn to feel comfortable saying "no" to too much—or any—alcohol in social situations. If you have older clients who enjoy the social aspects of drinking in these settings but engage in alcohol misuse, educate them about the importance of reducing their alcohol intake.[1179]

Promoting Wellness Strategies for Older Adults

This section reviews the eight dimensions of wellness and how to explore wellness from a client-centered perspective. It then examines strategies for promoting wellness, illness self-management and relapse prevention approaches, and strategies for promoting resilience and empowerment relevant to older adults in recovery from substance misuse.

What Is Wellness for Older Adults in Recovery?

Wellness is not simply abstinence from alcohol or drugs or the absence of illness or stress; it is being in good physical, emotional, and mental health.[1180] To better promote wellness and recovery in older adults, effective strategies should include a focus on illness self-management and relapse prevention and an emphasis on health potential.[1181]

SAMHSA has identified eight dimensions of wellness[1182] (Exhibit 7.2) that further a person's health, well-being, and recovery from substance misuse and mental disorders:

- **Emotional**—Coping effectively with life and creating satisfying relationships
- **Environmental**—Occupying pleasant, stimulating environments that support well-being
- **Financial**—Being satisfied with current and future financial situations
- **Intellectual**—Recognizing creative abilities and finding ways to expand knowledge and skills
- **Occupational**—Personal satisfaction and enrichment from one's work
- **Physical**—Recognizing the need for physical activity, healthy foods, and sleep
- **Social**—Developing a sense of connection, belonging, and a well-developed support system
- **Spiritual**—Expanding a sense of purpose and meaning in life

The consensus panel recommends that you explore all of these dimensions of wellness as a way to help older adults sustain their recovery from substance misuse.

Talk with clients about their own wellness goals in each of the eight dimensions. (See "Collaborative Goal Setting" in this chapter for more information.) This will help you understand what wellness means to each client and open the conversation about ways to develop health and wellness in recovery. (See the Chapter 7 Appendix for the Health Enhancement Lifestyle tool to assess older adults' health and wellness.)

For older adults in retirement, occupational wellness may be more about satisfaction and enrichment from nonpaid work such as volunteering in the community or a satisfying hobby like gardening or painting.

EXHIBIT 7.2. SAMHSA Wellness Wheel

Reprinted from material in the public domain.[1183]

Promoting Health and Wellness in Recovery

You can promote health and wellness among older adults in recovery from substance misuse by exploring obstacles to recovery, understanding their perspectives on health and wellness, and supporting their interest in and readiness to engage in activities that maximize health and wellness. The consensus panel recommends the strategies discussed below, which apply to diverse clinical and service settings, for promoting wellness among older adults in recovery.

General Wellness Promotion Strategies

Reduce fear, shame, guilt, and defensiveness related to substance misuse. Older adults may feel shame and guilt about acknowledging that they misuse substances. The first step in helping them achieve better health and wellness is to address their misconceptions about substance misuse and any fears they may have about treatment and the recovery process. One helpful strategy is to discuss substance misuse in a nonjudgmental way as a health issue like any other chronic illness (e.g., diabetes). Also express understanding and compassion to help older adults manage their fears and uncertainties about recovery from substance misuse and ways to engage in wellness activities to improve their health and well-being.[1184]

Identify wellness activities. Use the table in Exhibit 7.3 with clients to identify wellness activities that they find accessible, acceptable, and appropriate. Introduce the table by describing the eight dimensions of wellness and give some examples of activities in each domain. Then brainstorm with clients to identify specific activities in each domain that fit their preferences and wellness goals. With express consent from clients, ask supportive family members for suggestions on activities.

EXHIBIT 7.3. Identifying Wellness Activities

DOMAINS	EXAMPLES	CLIENT IDEAS
Emotional	Join a recovery or other support group; engage in storytelling with family or friends; keep a life history journal.	
Environmental	Make home modifications to age in place; create a quiet space at home; plant a flower box; seek "senior-friendly" safe housing.	
Financial	Organize financial documents; seek financial planning assistance.	
Intellectual	Join a book club; take an adult education or senior college class; learn a new skill; mentor a youth; teach a course or workshop.	
Occupational	Volunteer (e.g., become an AA or NA sponsor); get involved in advocacy initiatives; participate actively in a new or old hobby.	
Physical	Exercise by walking, dancing, swimming, or doing yoga or tai chi; eat healthy foods; develop a healthy sleep routine.	
Social	Go on group outings, such as to museums or historical sites; join a bridge club; take a cooking class.	
Spiritual	Join a faith-based or spiritual fellowship; meditate or pray; read inspirational material.	

Strategies To Increase Motivation

Increase motivation to change health risk behaviors and participate in wellness activities through motivational interviewing (MI). MI is a nonconfrontational, respectful approach that can effectively help older adults resolve ambivalence about change and increase motivation to change a target behavior.[1185] MI strategies can help older adults reduce alcohol consumption and tobacco use, improve general health, increase physical activity and exercise, improve diet, reduce cardiovascular risk factors, lose weight, and prevent disease.[1186,1187]

MI strategies can help older adults change health risk behaviors like intentional or unintentional misuse of prescription medications, and resolve ambivalence about participating in wellness activities. Use the following MI strategies to help older clients identify and plan for achieving target behaviors that reduce health risk, improve wellness, and sustain recovery from substance misuse:

- **Identify a specific target behavior** that the client is willing to explore (e.g., attending an educational session about the health risks of medication misuse for older adults or calling the local senior center to find out about a tai chi class). The more specific the target behavior, the more likely you and the older adult will be able to work together toward achieving the client's change goal.
- **Apply MI communication skills** (e.g., OARS—open questions, affirmations, reflective listening, and summarization) to shape the conversation with clients to help them resolve ambivalence about change. (See the Chapter 7 Appendix for an example of using OARS.)
- **Emphasize change talk** through reflective listening.
- **Help the client create a change plan** for each target behavior by writing down the change goal and a timeframe for achieving that goal. (The "Collaborative Goal Setting" section has more information.)
- **Follow up with the client** to see whether the change plan is working or needs adjustment.

For more on MI, see SAMHSA's 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).

Educational Strategies To Address Nutrition, Exercise, and Fall Prevention

Provide education on nutrition, exercise, and fall prevention. Access to health information, a key component of health literacy, enables people to better manage their health and sustain recovery. Three key elements of preventive care for older adults in recovery from substance misuse are nutrition, exercise, and fall prevention. You don't need to be an expert in nutrition or fitness to provide older adults with accurate information about health. Just knowing a few things about these elements of wellness for older adults can help you get the conversation started.

> Advise older clients to check with their healthcare provider before starting or dramatically changing their exercise routine or diet.

Begin by educating yourself. Explore the resources listed in the Resource Alert below for information on nutrition, exercise, and fall prevention for older adults. Then take a client-centered approach to client education and information exchange using these strategies:

- **Ask older clients what they know** about nutrition, exercise, and fall prevention for people their age.
- **Provide small chunks of information** that are personally relevant to older clients; use visual aids.
- **Ask clients what they think of this information** and how it affects their level of interest in or readiness to engage in health promotion activities.

- **Develop an individualized change plan.** If the information has an impact and clients are ready to act, brainstorm activities that they think are fun, easy, accessible, and personally relevant.
- **Follow up at the next visit.** Ask clients what worked and did not work, and help them adjust the change plan while making progress toward change goals.

Client education is a process of information exchange over time, not a single event. Information exchange can help you build a closer relationship with clients through a deeper understanding of their own experiences with making health behavior changes.

RESOURCE ALERT: OLDER ADULT NUTRITION, EXERCISE, AND FALL PREVENTION

The National Institute on Aging's (NIA) Health Topics A-Z webpage (www.nia.nih.gov/health/topics) offers easy-to-read information specific to older adults on a range of health topics, including healthy eating, exercise, and fall prevention.

Engaging American Indian/Alaska Native Elders in Fall Prevention Programs (www.ncoa.org/resources/engaging-american-indianalaska-native-elders-falls-prevention-programs), a National Council on Aging tip sheet, offers culturally responsive, practical strategies for American Indian and Alaska Native elders on fall prevention.

Strategies for Complementary Therapies, Spirituality, and Ancillary Services

Encourage the informed use of complementary therapies and activities. Complementary and integrative medicine techniques can be categorized into three groups—natural products (e.g., vitamins, herbal products), mind–body practices (e.g., meditation, yoga), and other health approaches (e.g., homeopathy, naturopathy). (See "Resource Alert: Complementary and Integrative Health for Older Adults.") Many complementary therapies and activities are appropriate for helping older adults maintain good health and well-being in ongoing recovery. For example, owning or interacting with a pet (e.g., in animal-assisted therapy) can increase physical activity, improve cardiovascular functioning, enhance socialization, lower blood pressure, and decrease loneliness in some older adults.[1188] Tai chi, a low-impact exercise and meditative movement, may prevent falls by improving balance, strength, mobility, and flexibility.[1189,1190] It may also help older adults sleep better.[1191]

Practicing mindfulness has many mental, emotional, spiritual, and health benefits that can enhance older adults' sense of well-being. Mindfulness has been widely adapted and studied in the United States as a strategy for stress reduction and healthy coping. Mindfulness helps people develop open, nonjudgmental attention to present-moment experience. Older adults can use mindfulness skills to cope with stresses like physical pain and financial worries. Mindfulness may also increase older adults' social support, well-being, and ability to regulate emotional states like depression, anger, and anxiety.[1192]

You can incorporate mindfulness practices in work with older adults or refer your clients to local programs that teach mindfulness. For more on mindfulness and mindfulness-based programs, see the website of the Center for Mindfulness in Medicine, Health Care, and Society at www.umassmed.edu/cfm.

Other complementary therapies and wellness activities appropriate for older adults in recovery include:

- Gentle or senior-friendly yoga.
- Dance and movement therapy.
- Low-impact fitness programs.
- Swimming and water therapy.
- Meditation.

The consensus panel recommends that you explore the benefits and potential downsides of complementary therapies with your older clients and work collaboratively with them to find the right fit based on cost, level of physical and cognitive functioning needed to participate successfully, age-specific adaptations, and ease of access.

Explore the spiritual dimension of wellness and recovery. As mentioned previously, participation in religious or spiritual fellowship can expand the social dimension of wellness for older adults. For example, one recent study found that more frequent attendance at church among adults ages 50 and older is associated with a sense of belonging and greater spiritual support, which are in turn associated with a greater likelihood of positive self-report of health.[1193] Engagement in religious activities (e.g., praying, attending religious services) and spiritual practices (e.g., mindfulness, meditation), including the spiritual aspects of AA, are linked with better alcohol use outcomes, improved recovery from AUD, increased coping skills and ability to manage stress, decreased anxiety and depression, and improved cognition.[1194,1195]

To **explore the spiritual dimensions of wellness and recovery with older clients,** you can:

- Acknowledge that spirituality or religious engagement may be important to your clients' well-being.
- Be open to exploring clients' spiritual or religious beliefs and practices and their potential impact on clients' health, wellness, and recovery. Do not insert your own beliefs into the conversation.
- Explore how your clients' understanding of spirituality relates to their overall well-being, experience of recovery, sense of meaning and purpose, health, and coping with loss, stress, or adversity.
- Encourage active participation in personally relevant religious or spiritual activities such as attending religious services, attending AA or NA 12-Step meetings, praying, engaging in mindfulness or meditation, or "giving back" by becoming an AA or NA sponsor or volunteering in the community.

Actively link or refer older adults to ancillary services, such as:

- Health care provided by physicians with experience and training in geriatric medicine.
- Specialized pharmacy services.
- Health education programs.
- Disease prevention or wellness counseling services.
- Complementary therapies.
- Fitness programs for older adults.

Active linkage includes contacting the service or program you are referring your client to, getting a release from your client, giving written instructions to your client about how to access the service (e.g., name of provider, appointment time), and following up with the ancillary service provider via phone, letter, or email. (Chapter 4 of this TIP has more information about active linkage and referral management.)

RESOURCE ALERT: COMPLEMENTARY AND INTEGRATIVE HEALTH FOR OLDER ADULTS

These resources offer providers and consumers research-based information on some complementary and integrative medicine treatments for older adults:

- The American Society on Aging's blog post about mindfulness and older adults is easy to read and could serve as a useful one-page handout to clients (www.asaging.org/blog/be-here-now-and-age-mindfully).
- The American Geriatrics Society website GeriatricsCareOnline.org offers a useful summary of complementary and integrative medicine approaches. The site also includes a table of natural products and their interactions with prescribed medications as well as a summary of the evidence base for complementary and integrative medicine approaches as they relate to different health conditions common in aging (https://geriatricscareonline.org/FullText/B030/B030_VOL001_PART001_SEC002_CH012).

Recognize and explore strengths. Older adults have a great deal of knowledge from their own experience, practical wisdom, and a wide range of skills and abilities. A strengths-based approach assumes that people do not simply survive difficult life circumstances, including substance misuse and the aging process itself, but can thrive in recovery and achieve enhanced health and wellness. Exploring older adults' strengths

involves validating their interests, acknowledging and appreciating their successes, and inviting them to reflect on future possibilities.[1196]

Clinical Scenario: A Strengths-Based Intervention

Older adults in recovery from substance misuse who are widows or widowers may feel guilty about surviving and lose interest in life. The following scenario focuses on exploring an older adult's strengths to rekindle a sense of possibility about the future.

- **AUD Recovery and Loss:** An older adult in recovery from AUD drops out of AA after becoming a widower.
- **Treatment Setting:** Outpatient addiction treatment program
- **Provider:** Licensed alcohol and drug counselor
- **Treatment Strategy:** Strengths-based approach

Harry is 79 years old. He has been in recovery from AUD for 3 years. He initially attended AA meetings, became actively involved in the program, and attended recovery-oriented social gatherings with his wife, Ginny. When Ginny died suddenly, Harry stopped going to AA and isolated himself from family and friends. His daughter became worried about him and convinced him to go see a counselor.

At the initial interview, the provider acknowledges Harry for maintaining his abstinence through a very difficult time. This acknowledgement helps Harry feel more comfortable talking about how he has lost interest in going to meetings or spending time with family and friends. He says, "I just can't let myself have fun or feel joy anymore. It's like I would be betraying Ginny. I'm the alcoholic and she is the one who died too young. It should have been me."

The provider offers Harry an affirmation and an open question that directs the conversation toward exploring Harry's strengths and an alternative story about his pulling back from life, "I appreciate your efforts to honor Ginny's memory. It seems like you really respect and appreciate how other people have touched you and contributed so much to your life. Not everyone has that quality. How did you come by that ability?"

Harry begins to tell a story about how he learned about respecting others early in his life and how important being respectful is to him. This opens the door for the counselor to explore Harry's other strengths and abilities. "What other abilities or talents would you say have contributed to your life?"

As the provider helps Harry identify his strengths, Harry starts to believe in himself again and gives himself permission to feel good. His story about honoring Ginny changes. He sees another way he can honor his wife: by getting back to living his own life. He decides to call his former AA sponsor about returning to his home group.

Promoting Self-Management and Relapse Prevention

Perhaps the most critical tasks for older adults who misuse substances are to achieve stability and maintain ongoing recovery. Sustaining recovery is challenging without a sense of health and well-being, especially for older adults with co-occurring mental disorders or multiple chronic illnesses. Relapse prevention planning is the key to helping older adults identify potential relapse triggers and build coping skills. Engaging older adults in chronic illness self-management programs, relapse prevention planning, continuing care, and ongoing recovery support can help them maintain long-term recovery.

Chronic Illness Self-Management

Chronic illnesses can increase isolation and interfere with substance misuse recovery efforts. Mental disorders like depression and anxiety are common in older adults. So are chronic health conditions: 80 percent of older adults have at least one chronic health condition, such as diabetes, arthritis, hypertension, cardiovascular disease, pulmonary disease, and chronic pain.[1197] **Illness self-management programs are an important part of integrated and client-centered care. They improve health outcomes, help people maintain higher levels of health functioning, and enrich quality of life** by helping people develop skills to manage their symptoms and change attitudes and behaviors.[1198]

One such program, the Stanford Chronic Disease Self-Management Program (CDSMP),[1199] is an evidence-based approach that has demonstrated effectiveness with older adults. **CDSMP has helped people improve wellness across several dimensions,** such as through improvements in exercise, cognitive symptom management, and self-reported general health; decreases in health distress, fatigue, and disability; and reduced hospitalizations.[1200] To help older clients develop and sustain chronic illness self-management plans, CDSMP:

- Explores with clients how having a chronic condition affects them and how, if not properly managed, the condition may interfere with recovery from substance misuse.
- Addresses depression and anxiety, often associated with substance misuse and chronic illnesses.
- Acknowledges the challenges and successes of daily self-management of symptoms.
- Addresses ways to build structure into daily routines to support clients' ability to manage symptoms while emphasizing recovery and wellness activities (e.g., take medication as scheduled, have lunch with a friend, attend AA meetings or other support groups).
- Provides information on and links clients to local or online CDSMP services.
- Supports clients in their efforts to sustain self-management of symptoms while actively participating in recovery and wellness activities.

To find organizations that offer a licensed CDSMP, go to www.eblcprograms.org/evidence-based/map-of-programs. Also check with the AAA or the Aging and Disability Resource Center (if available) for your community.

The Self-Management Resource Center (www.selfmanagementresource.com) offers a variety of illness self-management programs, including an online program, originally developed by and housed at the Stanford Patient Education Research Center. The Self-Management Resource Center also provides information about training and licensing for organizations that would like to offer a CDSMP.

Clinical Scenario: Promoting Chronic Illness Self-Management

Older adults in recovery from substance misuse who have chronic medical conditions may feel ashamed of having an illness that limits their functioning and ability to engage in recovery activities. The following scenario focuses on an older adult's negative self-judgments about having a chronic medical condition.

- **AUD Recovery and Chronic Medical Condition:** An older adult in long-term recovery from AUD has a chronic medical condition.
- **Treatment Setting:** Hospital-based outpatient behavioral health program
- **Provider:** Licensed psychologist
- **Treatment Strategies:** Foster self-acceptance and promote chronic illness self-management activities.

Ruth is 69 years old, is in long-term AUD recovery, and has attended AA for many years. She lives with her daughter and two grandchildren. Her daughter is divorced and works full time. Ruth watches her grandchildren after school. She became the General Service Representative of her home AA group and sponsored many members over the years. She smoked cigarettes for 20 years. Ruth frequently tells people that "smoking is a bad habit I picked up at meetings." She recently stopped after she was diagnosed with chronic obstructive pulmonary disease (COPD). Ruth's pulmonologist referred her to counseling at the hospital's outpatient program given her score of 12 on the Patient Health Questionnaire, indicating moderate depression. (Chapter 3 of this TIP offers screening and assessment tools.) She also was not following instructions for managing her COPD.

In counseling, Ruth discloses that she feels ashamed that she has COPD. She stopped going to AA meetings because she feels like a failure for having a chronic medical condition that she says she should have avoided. She also finds it more and more difficult to leave the house. Her energy is low, and she coughs all the time. She also states that she has recently felt like drinking after seeing alcohol commercials on TV.

The provider helps Ruth identify specific self-judgments about COPD. Ruth says, "I hate being sick all the time. I don't want another chronic illness. It's my fault for not taking care of myself. I really failed this time." The provider helps her reevaluate her perspective about what it means to have a chronic illness and how to manage it, using her experience in recovery as an analogy. The provider says, "You told me that when you first got into recovery, you felt a lot of shame. But you started to feel more accepting when other people talked about alcoholism as a disease that has no cure but can be managed a day at a time." Ruth tells the provider that she benefited from having a support group to help her learn about her disease, how to accept it, and ways to manage it.

The provider asks Ruth how she quit smoking after 20 years and avoided drinking. She says that she got a nicotine patch and went to a quit smoking group at the hospital. The provider says, "So it seems like you used some of the same tools you used to get sober to stop smoking and stay sober too." Ruth says, "I guess I'm not such a failure. If I can stay sober for this long and quit smoking after 20 years, I can learn to manage the COPD."

The provider then explores possible community COPD support resources, including a pulmonary rehabilitation program at the hospital that teaches people about COPD, how to manage their symptoms, and how to save their energy for other activities. Ruth agrees to sign up for the program. She says, "If I can get this thing under control and I have more energy, I'm sure I can get back to my home group. I really miss everyone."

Ruth and her provider agree to keep meeting while Ruth is in the pulmonary rehabilitation program to monitor her progress and explore any obstacles to returning to AA and staying focused on managing her COPD.

Continuing Care and Relapse Prevention

Continuing care in addiction treatment has traditionally consisted of short-term (e.g., 12-week) outpatient group counseling and passive referral to mutual-help groups. Current thinking about **continuing care emphasizes interventions that are long term and flexible enough to adjust to the needs of clients as they move through different stages of recovery.**

Staying longer in addiction treatment and having a social support system after treatment that reinforces abstinence from alcohol and illicit drugs are two of the most important factors associated with long-term recovery for older adults.[1201] Continuing care for older adults should emphasize:

- Retention in ongoing treatment and recovery support, including mutual-help group meetings.
- Relapse prevention planning.
- Use of in-home or telephone counseling as appropriate to strengthen retention and engagement.
- Active involvement (with the older adults' permission) of spouses and other family members, or other significant others who support the older adults' recovery.
- Active linkage to and follow-up with community-based resources, such as housing and employment services (when needed); senior centers; and fitness, health, and wellness services for older adults.

Also, some individuals find treatment facility alumni programs helpful in supporting their recovery from SUDs. Alumni programs typically offer graduates of the same treatment facility ongoing support through organized activities, continued contact with treatment staff, and further addiction education.

SOCIAL NETWORK COUNSELING

Network Support is a counseling intervention that consists of 12 counseling sessions (some including a spouse or significant other) that emphasize AA as a mutual-help group where people can make new friends and engage in nondrinking social and recreational activities. This approach can change the social network of the participants to include more nondrinking friends, which in turn can increase self-efficacy and coping, leading to improvements in long-term drinking outcomes.[1202] A key to ongoing recovery for older adults is a social network that supports recovery. When talking with older adults about the benefits of AA, emphasize the social aspects of mutual-help group attendance, an important factor in sustaining long-term recovery.

Relapse prevention planning is an important part of treatment and continuing care. You can facilitate this process by understanding older adult-specific relapse risk factors and strategies for reducing the risk of a return to substance misuse.

Some factors that increase the risk of relapse for older adults who misuse substances[1203] include:

- Loneliness and isolation.
- Boredom.
- Chronic pain.
- Untreated mental disorders or symptoms of anxiety and depression.
- Complicated grief.
- Sleep problems.
- Lack of social support for recovery.
- Chronic medical problems.
- Unsafe or unsuitable living environment.
- Prolonged stress.
- Difficulty managing instrumental ADLs including finances.
- Misunderstanding of relapse or lack of a relapse prevention plan.

Support your older clients in maintaining ongoing recovery and reducing the risk of relapse by:[1204,1205,1206]

- Helping them develop meaningful leisure, social, or vocational activities.
- Working with them and their physicians on alternative pain management strategies.
- Addressing grief issues throughout treatment and referring for additional supportive services when needed. (See the grief resource in the Chapter 4 Appendix of this TIP.)
- Providing information about good sleep habits (e.g., give up a daytime nap if it interferes with sleep at night) and low-risk nonpharmacological ways to cope with sleep problems.
- Ensuring that co-occurring mental and physical disorders get addressed and treated.
- Ensuring that they are keeping medical appointments, taking medications as prescribed, and communicating changes in health status to their healthcare providers.
- Teaching them stress management and coping skills throughout treatment.
- Helping them develop or broaden social networks that support recovery.
- Developing relapse prevention plans tailored to their individual needs.
- Exploring the potential for a return to substance use, normalizing relapse without implying that it is inevitable, and reframing relapse as a learning opportunity.
- Reviewing their past success in managing triggers; discussing themes and triggers for past relapses.
- Developing plans for reengaging in treatment if they return to substance use before it becomes a full relapse to previous levels of use.
- Working with them to evaluate coping strategies and, if needed, retrain on existing strategies or develop new ones.
- If appropriate to your role and setting, sustaining long-term supportive contact with them, with the emphasis on helping them maintain stability in recovery and better health and wellness.

Promoting Resilience and Empowerment in Recovery

Interventions that promote resilience can support relapse prevention efforts.[1207] **Thinking of older adults as inflexible or "set in their ways" is ageist and fails to acknowledge the skills, abilities, and wisdom they have acquired from years of experience.** Instead, promote resilience and empower your older clients in recovery from substance misuse by:

- Learning about their unique life-course events and challenges.
- Tapping into their wisdom.
- Supporting them in reflecting on successful resolutions to past challenges they have faced.
- Helping them build coping skills to meet the challenges of recovery from substance misuse.

Tasks and Challenges of Aging

Developmental theory suggests that a person has unique, age-specific tasks to master over the life course. The tasks of older adulthood can be challenging, yet rewarding, and include:

- Adjusting to decreasing physical health, strength, and cognitive functioning.
- Adjusting to retirement and reduced income.
- Trying new activities (e.g., creative hobbies limited earlier by career, job, or family responsibilities).
- Establishing safe housing and satisfactory living arrangements.
- Entering new social roles, including affiliating with one's age group, caring for relatives (particularly relevant for women), and grandparenting.
- Adjusting to and accepting the death of a spouse, other family members, or friends.
- Finding meaning in life while facing the prospect of death.[1208]

One way to think about the challenges of aging is to understand that with age comes a broad spectrum of losses and transitions that may be traumatic for the older adult. Work from a perspective of trauma-informed care, which assumes that older clients' presenting issues, behaviors, and emotional reactions may be adaptive responses to trauma or loss and not symptoms of pathology.

The consensus panel recommends that you approach every older adult in SUD treatment or recovery from a trauma-informed and person-centered perspective that recognizes that the experiences of trauma, loss, and grief are highly individualized.

> See SAMHSA's TIP 57, *Trauma-Informed Care in Behavioral Health Services*, for an indepth examination of a trauma-informed approach to the treatment and prevention of addiction and mental illness (https://store.samhsa.gov/product/TIP-57-Trauma-Informed-Care-in-Behavioral-Health-Services/SMA14-4816). See also www.samhsa.gov/trauma-violence.

Despite age-related losses and limitations on physical and cognitive functioning, older adults can experience mental growth and maturation.[1209] Most older adults maintain a positive outlook, improve their emotional regulation over time, and express a high degree of life satisfaction. Many older adults rise to the challenge, rediscover themselves, and grow from traumatic or stressful experiences. You can support your older clients in recovery in addressing the tasks and challenges of aging by:

- Recognizing that loss and transition are a normal part of aging and helping your older clients identify the losses and transitions specific to them.
- Recognizing that your older clients who have experienced the death of a spouse or intimate partner are at higher risk for starting or returning to alcohol misuse or drug use.
- Connecting your older clients with recovery supports when the urge to drink or use drugs arises.
- Recognizing that multiple losses may trigger trauma reactions in older adults with a history of depression, anxiety, or other mental disorders, including posttraumatic stress disorder, and treating co-occurring mental disorders concurrently.
- Helping your older clients identify day-to-day coping strategies, including maintaining a regular schedule, which helps people structure activities and maintain participation in social activities.[1210]
- Helping your older clients accept supports and services needed to maximize functioning and independence.
- Aiding them in balancing distraction from negative emotions with acceptance and learning to tolerate intense emotions associated with trauma.
- Helping clients identify personally relevant strategies for coping with and making meaning of loss and managing normal feelings of grief.
- Exploring with them whether reconnecting to a faith community could provide meaning and purpose.

- Linking clients in institutional settings (e.g., hospitals, assisted living) to mutual-help groups that provide meetings in such settings, if available.
- Helping clients build bridges to new sources of meaning and purpose.[1211]
- Exploring with clients the role adjustments they may face related to retirement; death of a spouse, other family members, friends, or a sponsor; a move to another geographic area; or taking on a parenting role for grandchildren.
- Helping clients build and strengthen their support networks.
- Encouraging them to explore creative ways to make amends, bring closure to a chapter in their life, celebrate past accomplishments and new developments in their life, or remember a significant other (e.g., creating personally meaningful rituals and ceremonies, writing therapeutic letters, creating memory books).

Strategies for Strengthening Resilience

To help your older clients foster resilience, encourage them to recognize that they can develop cognitive, emotional, and behavioral coping skills that strengthen their ability to prevent relapse, manage stress, and rebound from adversity. Bolstering resilience in older adults helps promote healthy aging, improves responses to developmental tasks and challenges, and heightens quality of life.[1212] The ability to cope with stressful situations is a key factor in preventing relapse from SUDs (see Resource Alert).

RESOURCE ALERT: STRATEGIES FOR BUILDING RESILIENCE[1213]

An American Psychological Association webpage (www.apa.org/topics/resilience) describes strategies people can use in supporting recovery from SUDs.

Collaborative Goal Setting

Collaborative goal setting draws on clients' strengths and focuses on developing attainable goals. This can promote a positive attitude toward changing substance misuse behaviors[1214] and create a sense of self-efficacy and hope for older adults in ongoing recovery. Goals should be personally relevant to your older clients, challenging but realistic, achievable, and specific.[1215]

As a provider, you can facilitate goal setting with your older clients by:

- **Helping them identify emotionally meaningful goals** that support recovery and improve health and wellness (e.g., spending more time with family and friends, maintaining independence or recovery support, aging in place).
- **Targeting short-term, easily attainable goals that build toward larger goals.** For example, to stop alcohol use, help clients identify activities to do instead of drinking (like going out to dinner with a nondrinking friend rather than staying home at night drinking).
- **Collaborating with your clients to develop a SMART plan** (Exhibit 7.4) for achieving the identified substance misuse or wellness goal; the plan should specify a timeframe and any supports clients need to meet the goal.
- **Monitoring progress toward meeting goals** for reducing or stopping substance misuse or engaging in wellness activities.
- **Helping clients modify goals as needed.** Questions you can ask your older clients include:
  - Was your initial goal too easy or too hard?
  - Would accomplishing smaller tasks, like reducing your alcohol intake, make it easier to accomplish your ultimate goal of stopping completely?
  - What obstacles prevented you from achieving or maintaining abstinence?
  - What obstacles prevented you from starting the wellness activity (e.g., taking a walk every day)?
  - What are some of your strategies for overcoming these obstacles?
  - Is your goal still important to you, or is it time to move to a different goal?

EXHIBIT 7.4. Writing a SMART Goal

Specific: State the goal clearly. Ask the client to be specific. For example, if the goal is "I just want to be healthy," ask "How will you know when you are 'healthy'?" or "What things will you be able to do when you are healthy that you can't do now?"

Measurable: Identify and quantify the observable markers of progress, such as pain levels or the number of days and amount of time the client walked each week. Invite the client to keep a log of these markers so you can discuss the client's progress.

Attainable: Break the goal into smaller, actionable steps. Identify expected barriers and make a plan to address them. For example, if the goal is to get 8 hours of sleep each night, break the goal into smaller tasks, like turn all the lights in the bedroom off at 10 p.m. at least five nights a week. Then ask, "What might keep you from turning the lights off at 10 p.m.?"

Relevant: Make sure the goal reflects what's personally relevant to the individual. Use MI to set the agenda and determine goals on which to focus. Link goals, such as blood pressure control, to the goal of staying healthy.

Time-bound: Define when the goal is to be attained. Help the client be specific about the timeframe. Make it realistic and attainable, based on the client's subjective evaluation. Agree when to check progress.

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Help older clients learn which health and wellness activities will help them prevent return to substance misuse, broaden social networks, build resilience, and give meaning and purpose to ongoing recovery.

Chapter 7 Resources

Provider Resources

A Clinician's Guide to CBT With Older People (www.uea.ac.uk/documents/246046/11919343/CBT_BOOKLET_FINAL_FEB2016%287%29.pdf/280459ae-a1b8-4c31-a1b3-173c524330c9): This workbook explores age-sensitive strategies for adapting cognitive–behavioral therapy for older adults.

Centers for Disease Control and Prevention (CDC)—Alzheimer's Disease and Healthy Aging (www.cdc.gov/aging/index.html): CDC offers educational materials and resources to help healthcare providers engage in activities of its Healthy Aging Program.

Centers for Medicare and Medicaid Services—*Annual Wellness Visit* (www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/AWV_chart_ICN905706.pdf): Healthcare providers can use this booklet to learn about the elements of the Health Risk Assessment and the Annual Wellness Visit.

National Council on Aging—Center for Healthy Aging (www.ncoa.org/center-for-healthy-aging): The Center for Healthy Aging provides educational resources for providers on health and wellness, disease management, nutrition, exercise, and fall prevention for older adults.

NIA—Health Topics A-Z (www.nia.nih.gov/health/topics): NIA provides an alphabetical listing of educational resources and information that may be useful for providers when educating older adults on health and wellness topics.

Consumer Resources

Administration on Aging—Eldercare Locator (https://eldercare.acl.gov/Public/Index.aspx): The locator connects older adults and their families to local services.

Eldercare Locator—*Expand Your Circles: Prevent Isolation and Loneliness As You Age* (https://eldercare.acl.gov/Public/Resources/Brochures/docs/Expanding-Circles.pdf): This easy-to-read brochure offers tips to older adults about expanding their social networks.

National Council on Aging—Resources (www.ncoa.org/audience/older-adults-caregivers-resources/?post_type=ncoaresource): This webpage contains a searchable database of articles, webinars, and other resources.

NIA—Alcohol Use or Abuse (www.nia.nih.gov/health/topics/alcohol-use-or-abuse): This webpage has links to information for older adults and family members about alcohol misuse.

NIA—*Older Adults and Alcohol: You Can Get Help* (https://order.nia.nih.gov/sites/default/files/2018-01/older-adults-and-alcohol.pdf): This easy-to-read consumer brochure lays out the issues and answers common questions that older adults have about drinking.

Silver Sneakers—Health and Fitness for Older Adults (www.silversneakers.com): Silver Sneakers connects eligible older adults on some Medicare plans to free memberships at fitness programs across the nation. This website also offers general information about wellness and fitness for older adults.

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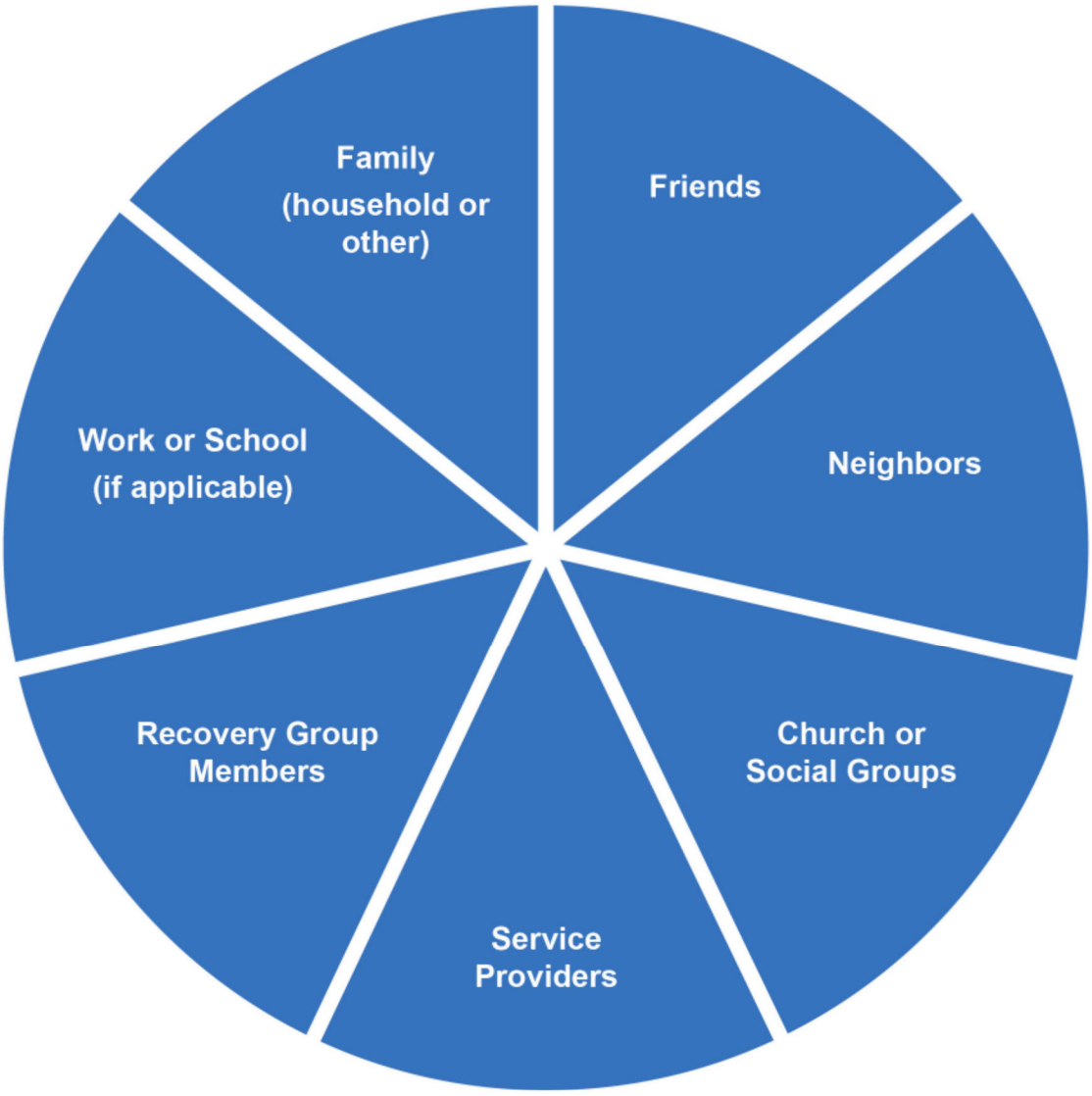
Chapter 7 Appendix

Assessing Social Support

The Social Network Map is a handy visual tool to help you and your clients identify members of their social network and the types of support they provide.[1217] It was developed as a clinical tool for assessing and broadening social support resources for families and has been used in studies to map social networks of older adults and adults with SUDs.[1218] The Social Network Map is a client-centered tool that collects information on the composition of older adults' networks, the extent to which network members provide different types of support, and the nature of relationships within the networks.[1219] The version depicted below is adapted for use with older adults in recovery.

SOCIAL NETWORK MAP FOR OLDER ADULTS IN RECOVERY



Adapted from Tracy & Whittaker (1990).[1220]

The following strategies[1221] will help you and your older clients develop a social network map:

- Create a pie chart with the seven domains. Health, behavioral health service, social service, and peer recovery support providers may be part of the support network clients identify.
- Ask older clients to identify members of their social networks by first name or initials only.
- Ask clients to describe how available (e.g., rarely, sometimes, often) each member of the network is to give emotional, instrumental, or informational support. Give examples and be specific:
  - "Who is available to give you emotional support like comforting you if you are upset or listening if you are stressed?" "How often does this person give you that kind of support?"
  - "Who is available to help you out in a concrete way like giving you a ride or helping with a chore?" "How often does this person give you that kind of support?"
  - "Who would give you information on how to do something new or help you make a big decision?" "How often does this person give you that kind of support?"
- Note the type and frequency of support each person listed in each domain can offer.
- Ask clients to describe how close they are to each member of their network, how long they have known them, and how frequently they see them.
- Ask clients to review the map and identify types of support that may be lacking and strategies for adding new network members to beef up their social support.

Assessing Isolation

Assess older adults' level of social isolation and explore all possible sources of social support they have. The **Lubben Social Network Scale (LSNS)** is designed for use with older adults. It measures social isolation and focuses on the nature of older adults' relationships with family and friends.[1222] Older clients can easily complete **the six-item short version (LSNS-6),** a self-report questionnaire. The LSNS-6 is available via www.bc.edu/content/bc-web/schools/ssw/sites/lubben/description.html.

For the LSNS-6, the total score (0–30) is an equally weighted sum of the scale's six items. A score below 12 indicates social isolation and need for further assessment.[1223] Low scores are associated with increased mortality, hospitalization for all causes, physical health problems, depression and other mental disorders, and low adherence to health-promoting activities.[1224] The Modified LSNS-R, with a "family of choice" subscale, was developed for use with lesbian older adults.[1225]

A screening tool like the LSNS-6 will give you an overall sense of the number of people in an older adult's life who provide support and the level of social isolation or social support the older adult is experiencing. The next step is to explore the kinds of social support older adults have or would like to have. This exploration will help you and your client generate strategies for increasing the diversity of social supports that promote health, wellness, and recovery.

Three types of social support enhance the health of older adults:

- **Emotional support** (e.g., feeling heard and understood, having help with reflecting on one's values, providing a sense that someone cares)
- **Instrumental support** (e.g., helping with finances, transportation, medication adherence)
- **Informational support** (e.g., providing information about community resources or the benefits of wellness and recovery activities, problem-solving, giving advice when asked)[1226]

Begin your conversation by describing the benefit of social support to people's health and well-being and give examples of the three types of support mentioned above. Then indicate that you would like to ask a few questions to see what kind of support your client already has.

Screening Instruments and Other Tools

The **Health Enhancement Lifestyle Profile (HELP)** is a validated assessment tool of older adults' habits and routines in health-promoting behaviors

in five of the eight dimensions of wellness. It is administered as either a self-report questionnaire or a structured interview.[1227] The HELP screening tool is a short version of the comprehensive assessment. It is a 15-item questionnaire that asks for "yes" or "no" responses. It is quick and easy to understand when administered to older adults as a self-report review of health-related lifestyle and wellness factors. (See page 32 of www.csudh.edu/Assets/csudh-sites/ot/docs/3%20Health%20Enhancement%20Lifestyle%20Profile%20(HELP)-Guide%20for%20Clinicians-2016.pdf for the screening tool.) The questions focus on exercise, nutrition, social support, recreational activities, and spirituality.

If further exploration is needed, focus the conversation with the client on items marked "no." For example, if the client marks "no" on the item about exercise, you might start with a nonjudgmental observation like *"I noticed that you normally don't exercise more than twice a week. Exercise can mean different things to different people. Tell me more about what you do for exercise."* This will open a conversation about physical activity and the client's understanding of what exercise is. Build on what the client is already doing before providing information about recommended guidelines or jumping in with advice about how to improve in that area.

The OARS approach is a person-centered communication approach used in motivational interviewing.[1228] You can use OARS throughout conversations with clients to help them feel relaxed, understood, and open to thinking about changing their pattern of substance misuse or engaging in wellness activities. Here are some examples of how to apply OARS to your discussions with older clients.

CLINICAL SKILLS: USING OARS IN CLIENT COMMUNICATIONS ON SUBSTANCE MISUSE

"O"—Open-ended questions: These questions help you learn more about the client's thoughts, feelings, and experiences. They are questions that cannot be answered with a simple "yes" or "no." Some examples are:

- "What do you think are some reasons for you to stop drinking?"
- "In what ways is not drinking important to you?"
- "How do you think your relationship with your daughter would be different if you were not using marijuana?"

"A"—Affirmations: These statements show support for the older adult's efforts to make difficult changes. Affirmations help the client build self-efficacy (a person's belief in his or her ability to do something, such as change a behavior). Examples of affirmations include:

- "Your willingness to discuss the risks of taking more pain medication than prescribed by your doctor fits right in with your health goals. I appreciate your willingness to talk about something that might be uncomfortable for you."
- "You are working hard to cut back on your drinking. When you set your mind to something you are determined to meet your goal."

"R"—Reflective listening: Reflective listening involves listening for the feelings or meaning of the client's statements and reflecting that meaning back to the client using his or her own words or paraphrasing. This shows that you are paying attention and trying to understand the client's perspective. Reflective listening also helps the client become more self-aware. You can use reflective listening by:

- Simply repeating key words or phrases back to the client.
- Rephrasing what the client said using your own words.

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- Reflecting the underlying meaning or feeling of the client's statement. Here is an example:
  - Client: "I started drinking more after my wife died. It just made the pain go away for a while. But then I fell and broke my hip one night after I had a few."
  - Provider: "Drinking helped you manage sadness temporarily, but then it started hurting your health."

"S"—Summarization: Summarizing is a form of reflective listening that ensures that you understand what the client has told you. It also helps you move the conversation to the next stage of the MI process. You can summarize by saying things like:

- "Let's review what we have talked about so far."
- "We covered a lot of topics this afternoon. Here's what it sounds like you're telling me."
- "You talked about your misuse of pain medications and how you have mixed feelings about that. You said that you are kind of scared to give them up completely, and the most important reason you can think of to taper off them is so you can have a better relationship with your grandson. Tell me a bit more about how important it is to have a better relationship with him and how getting off the medication will help you achieve that goal."