Substance Use, Recovery and APS Considerations

Instructor Led Training (Virtual or In-Person)

PARTICIPANT MANUAL

Academy for Professional Excellence

APSWI
Adult Protective Services Workforce Innovations

The Academy for Professional Excellence is a project of the San Diego State University School of Social Work

Funding Sources

This training was developed by the Academy for Professional Excellence, with funding from the California Department of Social Services, Adult Programs Division.

Curriculum Developer, 2024

Alice Joy Kirk, LCSW

Introduction

THE ACADEMY FOR PROFESSIONAL EXCELLENCE

We are pleased to welcome you to **Substance Use, Recovery and APS Considerations Participant Manual**, developed by Adult Protective Services Workforce Innovations (APSWI), a program of the Academy for Professional Excellence under a grant from the California Department of Social Services, Adult Programs Division.

The Academy for Professional Excellence, a project of San Diego State University School of Social Work, was established in 1996 with the goal of revolutionizing the way people work to ensure the world is a healthier place. Our services integrate culturally responsive and recovery-oriented practices into our daily work to promote healing and healthy relationships. Providing around 70,000 learning experiences to health and human service professionals annually, the Academy provides a variety of workforce development solutions in Southern California and beyond. With five programs, three divisions and over 100 staff, the Academy's mission is to provide exceptional learning and development experiences for the transformation of individuals, organizations and communities.

APSWI is a program of the Academy for Professional Excellence. APSWI is designed to provide competency-based, multidisciplinary training to Adult Protective Services professionals and their partners. APSWI's overarching goal is the professionalization of Adult Protective Services professionals to ensure that abused and vulnerable older adults and adults with disabilities receive high quality, effective interventions and services.

APSWI partners with state and national organizations and experts in the older adult and adults with disabilities professions to empower APS professionals and those they serve to live safely, peacefully and in a world that is free from abuse and neglect.

APSWI's partners include:

- National Adult Protective Services Association (NAPSA) Education Committee
- California Department of Social Services (CDSS), Adult Programs Division
- County Welfare Directors Association of California (CWDA), Protective Services Operations Committee (PSOC)
- California's Curriculum Advisory Committee (CAC)

Partner Organizations

Dawn Gibbons-McWayne, Program Manager, APSWI

Academy for Professional Excellence

https://theacademy.sdsu.edu/programs/apswi/

Kat Preston-Wager, Curriculum Development Supervisor, APSWI

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https://theacademy.sdsu.edu/programs/apswi/

Jennifer Spoeri, Executive Director, National Adult Protective Services Association (NAPSA)

https://www.napsa-now.org/

Paul Needham, Chair, NAPSA Education Committee

https://www.napsa-now.org/

James Treggiari, Adult Protective Services Liaison, Adult Protective Services Division

California Department of Public Social Services

https://www.cdss.ca.gov/adult-protective-services

Melinda Meeken and Carey Aldava, Co-Chairs, Protective Services Operations Committee of the County Welfare Director's Association (PSOC)

https://www.cwda.org/adult-protective-services

Acknowledgements

This training is the result of a collaborative effort between Adult Protective Services administrators, supervisors, staff development officers and workers across the state and the nation; professional educators; and the Academy for Professional Excellence staff members. APSWI would like to thank the following individuals and agencies:

Agencies

California Department of Social Services, Adult Programs Division National Adult Protective Services Association

Curriculum Advisory Committee

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Executive Summary

In this workshop, APS professionals will gain foundational information on substance use and misuse, substance use related disorders experienced by older adults and explore what recovery can mean to this population. This workshop promises to summarize various substances that are most likely to be used by older adults and consider the impact they have on older adults. Participants will use the Substance Abuse and Mental Health Services Administration's (SAMHSA) working definition of recovery and guiding principles, as they explore risk factors specific to older adults. They will also work within that definition to review assessments that APS can use in order to create collaborative service plans that include interventions that mitigate risk, empowering clients to live a life of recovery.

Virtual Training

- The following virtual instructional strategies are used throughout the course: a poll, lectures, large group discussions, and breakout groups helping participants apply interventions and SAMHSA principles to short case studies and examples. PowerPoint slides are used to help participants better define and retain the information provided.
- Participants will need access to a computer with video conferencing capability and be able to connect to the virtual platform being used to deliver this training. A headset or earbuds with microphone and a video camera are highly encouraged. Participant Manual is a fillable PDF if using Adobe Acrobat. Participants are encouraged to either print a hard copy or ensure access to Adobe Acrobat to allow for highlighting and note taking.

Course Requirements

- There are no course requirements but it is recommended that participants have some experience interviewing clients.
- It is recommended that participants print out Handouts provided prior to attending training.

Target Audience

This training is intended for new and experienced line staff who interview clients and collaterals, provide risk assessments and develop service plans.

Learning Objectives:

- Upon completion of this training participants will be able to:
- Define Substance Related Disorders
- Identify substances older adults are most susceptible to becoming dependent on

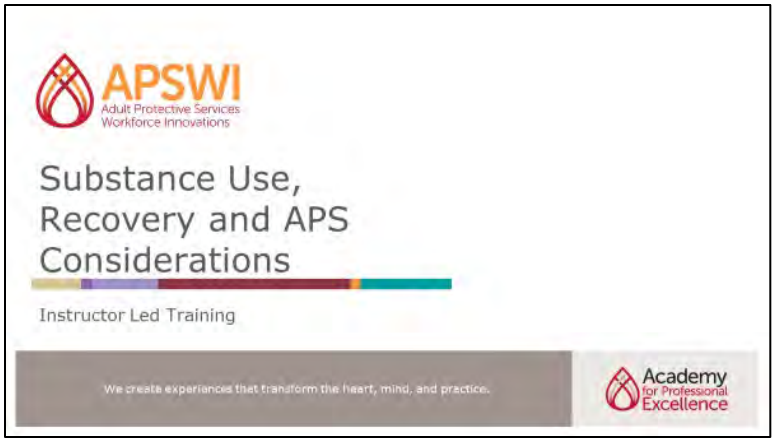
- Identify three risk factors of substance use disorders as seen in older adults and explain how those risk factors may impact the person
- Summarize SAMSHA's 10 principles of recovery as they apply to working with those served by APS
- Explain three interventions that can be used to create a collaborative service plan with someone experiencing a substance use disorder

Course Outline

CONTENT	MATERIALS	TIME
WELCOME, INTRODUCTIONS, COURSE OVERVIEW		**TOTAL: 20 Minutes**
• Welcome, Land Acknowledgment, Housekeeping, Technology, Content Warning		
• Participant Intro (name, agency, time in APS) • Activity #1- Connecting Together (*individual, large group)* • Course overview and Learning Objectives	Poll	
INTRODUCTION TO SUBSTANCE USE AND OLDER ADULTS		**TOTAL: 85 Minutes**
Unique Circumstances for Older Adults • People born between 1946-1964 • The Impact of Ageism on the Perception of Recovery • SAMHSA's 10 Guiding Principles • Activity #2 SAMHSA Principles of Recovery (*breakout groups*)	Handout #1	
Definitions of Substance Related and Substance Use Disorders • Falling Between the Cracks		
Substances Most Likely to Be Used • Alcohol • Cannabis • Prescription • Illicit		

Risk Factors • Demographics • Genetics & Environmental • Trauma • Co-Occurring/Dual Disorder • A Lifetime of Invisibility: The LGTBQ+ Population.		
RECOVERY & TREATMENT		**TOTAL: 45 Minutes**
Recovery and Treatment • Activity #3- Applying Principles to Scenarios (*breakout groups)* • Why Recovery Matters • Bias in Substance Use Disorder Treatment	Handouts #1, #2, #3	
INTERVIEWING & ASSESSMENTS		**TOTAL: 15 Minutes**
Tools for APS: • Interviewing Tips • Cage • SMAST-G • AUDIT-C		
INTERVENTIONS		**TOTAL: 90 Minutes**
Interventions • Person-Centered Interventions and Service Plans • Intervention Challenges • Brief Interventions for APS • Change, Discord and Sustain Talk o Activity #4 (Part 1)-Identifying Talk Type (*Large Group*) o Activity #4 (Part 2)- Video Demonstration (*Individual, Large Group*) o How to Respond to Talk Types • Psychoeducation • Primary/Geriatric Physician • Trauma Informed Care • Motivational Interviewing Core Concepts • Solution Focused • 12 Step Groups • Smart Recovery • Harm Reduction • Development of Healthy Coping Strategies & Protective Factors		

Activity #5- Identifying Appropriate Assessments and Interventions to scenarios (*individual, breakout groups)*	Handout #4	
WRAP UP AND EVALUATIONS		**15 minutes**
• Summary • Activity #6-PIE *(individual, large group)* • Evaluations		
TOTAL (EXCLUDING BREAKS)		**4.5 hours**



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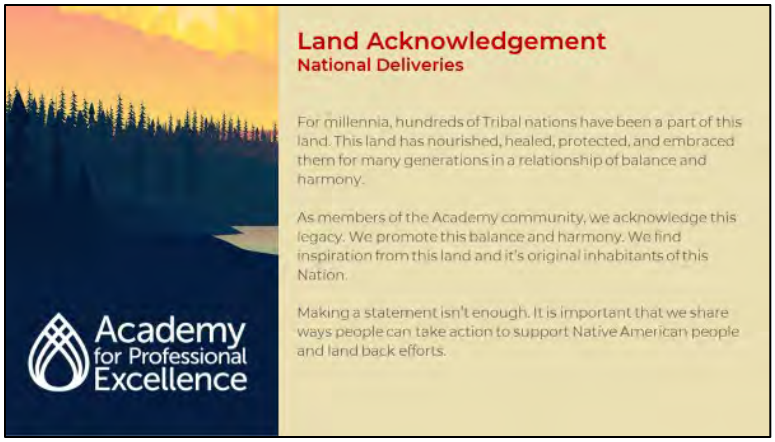

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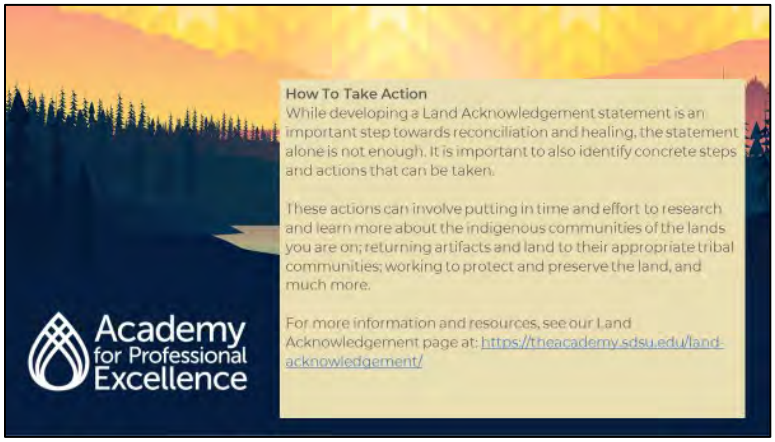

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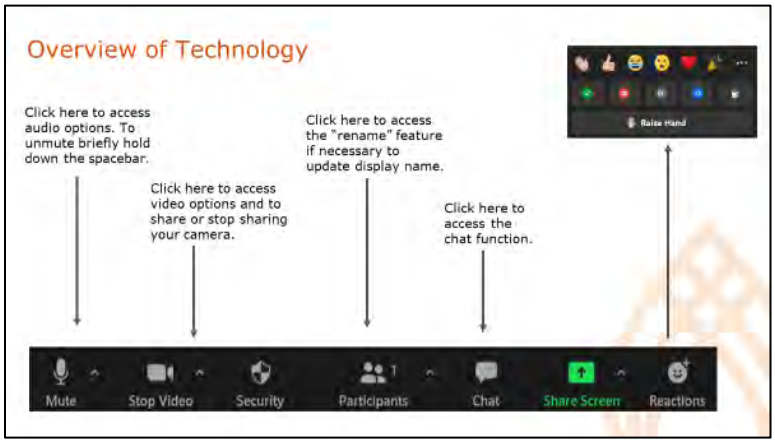

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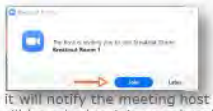
Breakout Rooms



- Joining the breakout room:
  - Click **join**
- Asking for Help:
  - If you click **Ask for Help**, it will notify the meeting host that you need assistance and they will be asked to join your breakout room
- Leaving the breakout room:
  - You can leave the breakout room and return to the main meeting session at any time
    - Click **Leave Breakout Room**
    - Choose if you want to leave the breakout room or the entire meeting.
  - When the host ends the breakout rooms, you will be notified and given the option to return to the main room immediately, or in 60 seconds.

Notes:

Poll

What is most challenging for you as an APS professional when working with someone experiencing substance use or misuse?

- Potential activation due to personal experiences.
- Sense of not being able to help.
- Lack of resources.
- Client's support system unable to help due to their own SUD issues.
- Not having adequate time to help.
- Other

Notes:

Course Overview and Learning Objectives

SAMHA's working definition of recovery: "*A process of change through which an individual improves their health and wellness, lives a self-directed life, and strives to reach their full potential*".

- Health
- Home
- Purpose
- Community

Learning Objectives:

- Define Substance Related Disorders
- Identify substances older adults are most susceptible to becoming dependent on
- Identify three risk factors of substance use disorders as seen in older adults and explain how those risk factors may impact the person
- Summarize SAMSHA's 10 principles of recovery as they apply to working with those served by APS
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Notes:

The Population We Serve

"Where you stumble there lies your treasure."
Joseph Campbell, Writer




Notes:

Unique Circumstances for Older Adults

In general:

- Less likely to seek treatment encouraging a perception of "less likely to have a problem."
- Societal idea older adults "age out" of Substance Use Disorders.
- Higher physical impact with a lower amount of use due to:
  - Other medication interactions
  - Higher rates of grief/loss
  - Physical and metabolic changes
  - Lower ability to recover from injury
- Last Hurrah, aka "Does it Matter?"
- May have more free time and may have a smaller support system.

Notes:

Unique Circumstances for People born between 1946-1964

People who are in their 60's and 70's are now:

- A very large population with the longest lifespan
- Came into adulthood between 1950's-1970's

What visuals, images, ideas do you have when you think of the 1950's to end of the 1970's?

Fast Forward:

- A generation more tolerant of substances—with older bodies more vulnerable to substances
- A Nation legalizing cannabis
- Pain management is mainly medication focused.
- Equates a changing picture of "Older Adult."

Notes:

The Impact of Ageism on The Perception of Recovery

Ageism exists consciously, or unconsciously, individually or systemically.

What negative messages does our society send about older individuals?

- Thoughts, jokes, actions.
- Treating older individuals with methods developed for younger individuals.
- Assuming possible symptoms of Substance Use Disorder for signs of aging.

Just as with any other systemic bias these messages *gives the individual messages about their own self-worth and abilities.*

APS professionals must bring a different message.

Notes:

SAMHSA's 10 Guiding Principles

Hope: The catalyst of recovery

Person Driven: Self determination & autonomy

Many Pathways: Personalized recovery

Holistic: Mind: Body, Spirit and Community

Peer Support: Mutual aid and encouragement

Relational: Those who provide hope, support, & new roles

Culture: Culturally grounded, sensitive and congruent

Trauma: Trauma Informed care promoting empowerment

Strengths & Responsibilities: Personal responsibility for the journey of recovery

Respect: Acknowledgement from others of the courage the journey of recovery takes

Notes:

Notes:

Handout #1- SAMHSA's Guiding Principles of Recovery

10 GUIDING PRINCIPLES OF RECOVERY

Hope	Relational
Person-Driven	Culture
Many Pathways	Addresses Trauma
Holistic	Strengths/Responsibility
Peer Support	Respect

Recovery emerges from hope

The belief that recovery is real provides the essential and motivating message of a better future—that people can and do overcome the internal and external challenges, barriers, and obstacles that confront them. Hope is internalized and can be fostered by peers, families, providers, allies, and others. Hope is the catalyst of the recovery process.

Recovery is person-driven

Self-determination and self-direction are the foundations for recovery as individuals define their own life goals and design their unique path(s) towards those goals. Individuals optimize their autonomy and independence to the greatest extent possible by leading, controlling, and exercising choice over the services and supports that assist their recovery and resilience. In so doing, they are empowered and provided the resources to make informed decisions, initiate recovery, build on their strengths, and gain or regain control over their lives.

4

Recovery occurs via many pathways

Individuals are unique with distinct needs, strengths, preferences, goals, culture, and backgrounds— including trauma experience — that affect and determine their pathway(s) to recovery. Recovery is built on the multiple capacities, strengths, talents, coping abilities, resources, and inherent value of each individual. Recovery pathways are highly personalized. They may include professional clinical treatment; use of medications; support from families and in schools; faith-based approaches; peer support; and other approaches. Recovery is non-linear, characterized by continual growth and improved functioning that may involve setbacks. Because setbacks are a natural, though not inevitable, part of the recovery process, it is essential to foster resilience for all individuals and families. Abstinence from the use of alcohol, illicit drugs, and non-prescribed medications is the goal for those with addictions. Use of tobacco and non-prescribed or illicit drugs is not safe for anyone. In some cases, recovery pathways can be enabled by creating a supportive environment. This is especially true for children, who may not have the legal or developmental capacity to set their own course.

Recovery is holistic

Recovery encompasses an individual's whole life, including mind, body, spirit, and community. This includes addressing: self-care practices, family, housing, employment, transportation, education, clinical treatment for mental disorders and substance use disorders, services and supports, primary healthcare, dental care, complementary and alternative services, faith, spirituality, creativity, social networks, and community participation. The array of services and supports available should be integrated and coordinated.

5

Recovery is supported by peers and allies

Mutual support and mutual aid groups, including the sharing of experiential knowledge and skills, as well as social learning, play an invaluable role in recovery. Peers encourage and engage other peers and provide each other with a vital sense of belonging, supportive relationships, valued roles, and community. Through helping others and giving back to the community, one helps one's self. Peer-operated supports and services provide important resources to assist people along their journeys of recovery and wellness. Professionals can also play an important role in the recovery process by providing clinical treatment and other services that support individuals in their chosen recovery paths. While peers and allies play an important role for many in recovery, their role for children and youth may be slightly different. Peer supports for families are very important for children with behavioral health problems and can also play a supportive role for youth in recovery.

Recovery is supported through relationship and social networks

An important factor in the recovery process is the presence and involvement of people who believe in the person's ability to recover; who offer hope, support, and encouragement; and who also suggest strategies and resources for change. Family members, peers, providers, faith groups, community members, and other allies form vital support networks. Through these relationships, people leave unhealthy and/or unfulfilling life roles behind and engage in new roles (e.g., partner, caregiver, friend, student, employee) that lead to a greater sense of belonging, personhood, empowerment, autonomy, social inclusion, and community participation.

Recovery is culturally-based and influenced

Culture and cultural background in all of its diverse representations—including values, traditions, and beliefs—are keys in determining a person's journey and unique pathway to recovery. Services should be culturally grounded, attuned, sensitive, congruent, and competent, as well as personalized to meet each individual's unique needs.

6

Recovery is supported by addressing trauma

The experience of trauma (such as physical or sexual abuse, domestic violence, war, disaster, and others) is often a precursor to or associated with alcohol and drug use, mental health problems, and related issues. Services and supports should be trauma-informed to foster safety (physical and emotional) and trust, as well as promote choice, empowerment, and collaboration.

Recovery involves individual, family, and community strengths and responsibility

Individuals, families, and communities have strengths and resources that serve as a foundation for recovery. In addition, individuals have a personal responsibility for their own self-care and journeys of recovery. Individuals should be supported in speaking for themselves. Families and significant others have responsibilities to support their loved ones, especially for children and youth in recovery. Communities have responsibilities to provide opportunities and resources to address discrimination and to foster social inclusion and recovery. Individuals in recovery also have a social responsibility and should have the ability to join with peers to speak collectively about their strengths, needs, wants, desires, and aspirations.

Recovery is based on respect

Community, systems, and societal acceptance and appreciation for people affected by mental health and substance use problems—including protecting their rights and eliminating discrimination—are crucial in achieving recovery. There is a need to acknowledge that taking steps towards recovery may require great courage. Self-acceptance, developing a positive and meaningful sense of identity, and regaining belief in one's self are particularly important.

7

Activity: SAMHSA's Principles of Recovery

- Read the SAMHSA 10 recovery principles. As you read:
  - Which of these resonate with you?
  - Which of these do you already use?
  - Which would you use in a service plan?
  - Which do our society honor and support in older adults?
- Discuss in the group.
- Decide who will share during report backs.

Notes:

Definition: Substance Related Disorders

There are two groups of substance related disorders;

1. *Substance use disorders: "Cluster of cognitive, behavioral and physiological symptoms indicating the individual continues to use despite excessive problems that use is causing"* (DSM 5,483).
2. Substance induced disorder—intoxication, withdrawal, neuro-cognitive disorders, delirium, substance induced mental health disorders. (We will not focus on this.)

Notes:

Substance Use Disorders

A cluster of cognitive, behavioral and physiological symptoms with the continued use of the substance.

Impaired Control
- Larger amounts, excessive time spent using, cravings.

Social Impairments & Consequences
- Continued use placed above responsibilities & relationships, including neglecting their ADLs/IADLs.

Continued Use despite awareness of Risks
- Recurrent use despite awareness of hazards, (Ex. Driving under influence).

Notes:

Falling Between the Cracks of DSM Criteria

- Substances taken in larger amount than intended.
  - *Older adults have impairments with smaller amounts.*
- Unsuccessful efforts to cut down.
  - *With long term use this an older adult may not recognize the need or attempt even attempt to cut down*
- Difficulty sustaining work, home or school responsibilities.
  - *Less obvious--More likely to be seen in lack of attending to health, ADL's or IADL'S. "What have they have given up or stopped doing?"*
- Substance use is not deterred by medical or psychiatric complications.
  - *Complications can occur faster, are more severe, and potentially permanent.*

Notes:

Older Adults: Substances Commonly Used

Types of substances commonly used are:

- Alcohol
- Prescription Opiates and Benzodiazepines
- Cannabis

Less likely:

- Heroin, fentanyl.
- Stimulants—methamphetamine, crack and cocaine
- Hallucinogens, LDS, PCP, ecstasy, molly, peyote, psilocybin

Notes:

Alcohol and Cannabis

Alcohol

- Recommendations for older adults = no more than 7 drinks per week
  - At risk drinking: 7+ drinks weekly, or 3+ per occasion.
  - Lifetime norms, mixed with metabolic changes, medical or neurological disorders = high risk.
  - APS can provide repeated psychoeducation as they may not be aware of effects of alcohol as they age.

Cannabis

- Fast growing: Pain and recreational use, many forms
  - APS can ask about various forms of use
- Outcomes of Cannabis use is unknown.
- Also unknown: "safe use." Recommend the client talk to their doctor.

Notes:

Prescription and Illicit Substances

Prescription Medications
- Polypharmacy: More than 4 medications in use
- Hyperpolypharmacy: More than 10
- Consequences: ADL's, Hospitalization, SNF's

Illicit Substances
- Bias: Older Adults "age out" of using illicit drugs
- "Baby Boomer" group are increasing the numbers:
  - A return, or continuation, of use
  - The encouragement from caretakers/support system

Notes:

Risk Factors in Older Adult Substance Use

Why can some people use substances without becoming a disorder?

Substance Use Disorders are a puzzle that has many pieces.
- Genetic vulnerability.
- Environmental reinforcements.
- Lived trauma.
- Mental Health
- LGBTQ+

Notes:

Risk Factors: Demographics

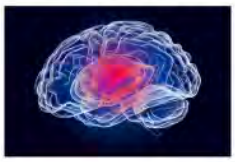
AGE:
- 2019:~10,300 people ages **55+** died from opioid overdoses
- Older adults get ~17 million Rx a year for tranquilizers (benzodiazepines)
- 250% increase in the # of adults 65+ reporting past-year cannabis use between 2006 and 2013

ETHNICITY/RACE and SEX:
- Being white, male, divorced or widowed is associated with higher odds of alcohol use disorder
- 2019: Opioid overdose deaths among Black men were 10X the rate of their age group
- Women have lower rates for alcohol/drug dependence or abuse, including illicit drugs

Notes:

Risk Factors: Genetics

- Research: Not about lack of willpower, about loss of control.
- Studies show genetics can increase risk.
- Substance Use Disorder is better treated as a **disease of the brain**.
  - For some, substance use "hijacks" the brain.
  - Pleasure from using decreases along with pleasure felt from all other activities.
  - Use can become about escaping negatives and chasing the highs.



Notes:

Risk Factors: Environment

Combined with genetic factors can create a slippery slope:

- Parents/Caregivers that normalize, or encourage, substance use.
- High Risk Families: Multi stressors, few behavioral alternatives, poor social support.

In Older Adulthood:

- Decreased social support
- Loss of important roles
- Taking on a caregiving role
- Painful health issues
- Encouragement of use by others.

Notes:

Risk Factors: Trauma

Trauma defines how one defines themselves, interprets their life & interacts with the world.

Childhood Trauma:

- Impaired nervous system and difficulty with emotion regulation.
- Stuck in survival mode—less development of complex thought

Impact on older adults who are in Erickson's stage: Life review—sense of integrity or sense of despair.

Learn about their history:

- Do they have a trauma history & how do they view themselves in relation to trauma?
  - *More than double the number of substance use disorders have been diagnosed in Veterans as opposed to a general population*
- Did additional factors make trauma more expansive; race, sexual orientation, gender.

Notes:

Risk Factors: Co-occurring (Dual Disorder)

- The hidden population: Harder to see, easier to dismiss.
- Most likely diagnosis:
  - Depression, anxiety & bi-polar
  - 4X more likely to use alcohol than younger population
- Importance of treatment minimized due to:
  - Length of time having the diagnosis.
  - Stigmatization.
- Need for services is severe due to medical and neurological conditions
- Start with where the client is (MI)
  - Work with the treatment and resources that are accessible.

Notes:

Risk Factors: LGBTQ+: A Lifetime of Invisibility

- A life lived without basic freedoms:
  - Public affection, having children, marriage, etc.
- Likely to have experienced:
  - Victimization, discrimination, denied health care, inability to disclose information to healthcare provider
- Higher rates of trauma and substance use disorders then a cisgender or heterosexual population.
- Visit: Center of Excellence (https://lgbtqequity.org/resources/)

Notes:

Recovery and Treatment

"Someone who is trying to be sober is often trying to work out deeper emotional issues and is attempting to undo years of habitual behavior.

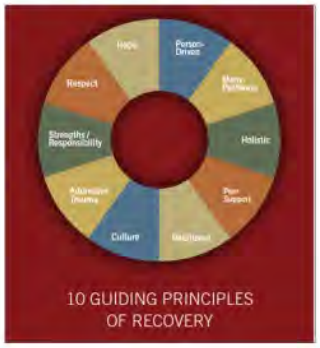
When you reduce recovery to just abstinence, it simplifies what is really a much more complex issue." -*Sasha Bronner, Senior Editor Huffington Post, Writer*

APS can:

- Develop collaborative service plans by:
  - Building protective factors
  - Offering alternatives.

Notes:

Applying Guiding Principles



Ethical Principles and Best Practice Guidelines

Dedicated to the memory of Ronald Hoffman, NAPSA 2018

Adult Protective Services *programs and staff promote safety, independence and quality-of-life for older persons and persons with disabilities who are being mistreated or in danger of being mistreated, and who are unable to protect themselves.*

Guiding Value: *Every action taken by Adult Protective Services must balance the duty to protect the safety of the vulnerable adult with the adult's right to self-determination.*
Secondary Value: *Older persons and persons with disabilities who are victims of mistreatment should be treated with honesty, caring and respect.*

Principles

- Adults have the right to be safe
- Adults retain all their civil and constitutional rights unless a court adjudicates otherwise
- Adults have the right to make decisions that do not conform with societal norms as long as these decisions do not harm others
- Adults have the right to accept or refuse services

Practice Guidelines

- Recognize that the interests of the adult are the first concern of any intervention
- Avoid imposing personal values on others
- Seek informed consent from the adult before providing services
- Respect the adult's right to keep personal information confidential
- Recognize individual differences such as cultural, historical and personal values
- Honor the right of adults to receive information about their choices and options in a form or manner that they can understand
- To the best of one's ability, involve the adult as much as possible in developing the service plan
- Focus on case planning that maximizes the vulnerable adult's independence and choice to the extent possible based on the adult's capacity
- Use the least restrictive services first whenever possible-community-based services rather than institutionally-based services
- Use family and informal support systems first as long as this is in the best interest of the adult
- Maintain clear and appropriate professional boundaries

Notes:

Application Activity

Using your assigned case scenario (**CONTENT WARNING**):

- Identify various SUD risk factors.
- Identify which of the SAMHSA 10 and/or NAPSA were used by the APS professional assigned to case.
- Identify which actions/plans from the APS professional were counter to those principles.

Notes:

Notes:

Handout #2: NAPSA's Ethical Principles

Ethical Principles and Best Practice Guidelines

Dedicated to the memory of Rosalie Wolf ©NAPSA 2018

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- Use the least restrictive services first whenever possible-community-based services rather than institutionally-based services
- Use family and informal support systems first as long as this is in the best interest of the adult
- Maintain clear and appropriate professional boundaries
- In the absence of an adult's expressed wishes, support casework actions that are in the adult's best interest
- Use substituted judgment in case planning when historical knowledge of the adult's values is available
- Do no harm. Inadequate or inappropriate intervention may be worse than no intervention

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Handout # 3: Application Scenarios

Scenario #1 (Content Warning)

Shonda: 63 years old, Black woman. Lost her wife 2 years ago in a car accident that they were both involved in. Isolation increased significantly because her wife was "the extroverted one" and Shonda also had survivor guilt and didn't want to be around others. She has fallen several times while walking her dog. She has also been observed multiple times in dirty clothing. A nosy neighbor took a quick look at her grocery delivery service bags when they were dropped off and saw three bottles of Don Julio. They decided to make an APS report out of concern for her falls, appearance and alcohol use.

APS professional: Talked to the reporting party before contacting Shonda. When entering Shonda's home sought to set her at ease by asking her about the artwork displayed throughout the home. Shonda appeared more relaxed after talking about her love of art and felt able to talk about her recent loss. The APS professional let Shonda know of his concern about possible substance use at which point Shonda began to cry about the neighbors that harassed her. Full of sympathy for how the neighbors were treating Shonda, he decided to discuss her fall risk while walking the dog and not pursue the possible alcohol issue.

1. Identify which SUD risk factors possibly exist.
2. Identify where SAMHSA's and NAPSA's principles are used.
3. Identify what was done that was counter to any of SAMHSA's or NAPSA's principles.

Scenario #2 (Content Warning)

Charles: 70 years old, White man. Raised by parents who had severe substance use issues. After living through molestation by an extended family member, he started using various substances himself but after many years of use, entered recovery and maintained years of sobriety. Developed osteoporosis and has severe pain, which has been managed by prescription pain pills. When mandated tracking requirements for prescription pills were instituted his doctor cut back on his medications. Charles began buying additional pills illicitly. His use increased and the cost did also. His caregiver became worried about everything they were seeing and filed an APS report.

APS professional: In recovery himself, read the report and felt a little frustrated that the client had relapsed after years of recovery. But—he could help this guy. He just had to remind Charles of what he had done before. The plan unfolded in his head. First, help Charles get a sense of hope. Next, help him understand that things could and would get better. Finally, talk to Charles about that first recovery and get him back on track. Because it sounded like Charles might have been a loner for a while now, the APS professional decided to not discuss Peer Support Groups and thought their "motivating conversation" was enough.

1. Identify which SUD risk factors possibly exist.
2. Identify where SAMHSA's and NAPSA's principles are used.
3. Identify what was done that was counter to any of SAMHSA's or NAPSA's principles.

Scenario # 3 (Content Warning)

Rainbow, 68 years old, White woman. Was proud of being one of the first hippies. Flower power, communal life, love-in's, peace signs, anti-war demonstrations, psychedelic bell bottoms and drugs, she had done it all. She witnessed several friends overdose throughout her teenage years. The drugs she used were mostly experimentation, except for the weed, which she used for years because it helped her manage her anxiety. The smorgasbord of weed that had grown since it was legalized reminded her of the fun and freedom of her teen years. Although she was surprised at how strong the stuff was nowadays. But she'd been smoking forever, she could handle it. The local cannabis shops no longer gave her the "first time member" discounts and Rainbow got behind in her bills and had multiple overdrawn transactions on her bank account. Faye, Rainbow's favorite Bank Teller at the Credit Union Rainbow had been a member of for 30 years, tried to discuss the overdrawn transactions with Rainbow and she blew it off to "just a little habit". Faye reported the concerns to APS.

APS professional: She smiled when she read the report thinking of someone named Rainbow growing up in the 60's/70's. Then she realized the severity. She knew that older adults were more susceptible to mobility hazards, cognitive issues, financial challenges when paired with substance use and that as active as Rainbow is, she'd probably end up getting a DUI someday. She wondered when was the last time the client had seen a doctor? That would be a good place to start. And she also realized she might have some biases after working in APS for so many years and probably needed to check herself on those assumptions. Who knew what the client had done in her life. And what she still might want to do. Was the cannabis use getting in the way of anything?

1. Identify which SUD risk factors possibly exist.
2. Identify where SAMHSA's and NAPSA's principles are used.
3. Identify what was done that was counter to any of SAMHSA's or NAPSA's principles.

Scenario #4 (Content Warning)

Gonzalo, 83 years old Hispanic man. With he and his wife being blessed with six children and being the primary breadwinner, working hard his entire life, he'd earned an early retirement. Finances were tight but he was careful. He and his beloved Areceli had lived quietly and happily, enjoying the grandchildren and their time together. She had passed away, in their home, about 10 years ago at age 67. He'd adjusted to her loss, but now, approaching 85, he seemed to miss her more. His kids loved him, but they were busy. His back injury kept him from using his hands; doing the building and repairing he loved. His time ticked by too slowly. He needed more in his life. He liked feeling busy and happy. Gonzalo kind of stumbled into using his pain medications for more than physical pain. First, he realized they made time slip away. He started using more than prescribed, which led to making excuses about why the pills were gone so quickly. That didn't work to well so then he started trying to get more pills before time for refills by exaggerating the pain when he talked to the doctor to get an increase in strength. One of his sons caught got suspicious when Gonzalo started neglecting his house, eating poorly and isolating away from his family until it became very noticeable. Gonzalo denied everything and his son, feeling scared about the father changing in front of him, phoned in a concern of self-neglect.

APS professional: Reading the report she had immediate respect for the client. The man had worked hard, raised kids that clearly loved him. When she interviewed the client, she could see and hear how much his back hurt and why he was taking the pain medication. She felt that Gonzalo had the right to make choices others did not approve of, like keeping the house messy, or eating junk food. And didn't he deserve it? This should be a fairly easy case- open the case, offer a support groups both at the church down the street and a Narcotics Anonymous group and close it.

1. Identify which SUD risk factors possibly exist.
2. Identify where SAMHSA's and NAPSA's principles are used.
3. Identify what was done that was counter to any of SAMHSA's or NAPSA's principles.

Why Recovery Matters

Recovery is:
- Building a life.
- A learning process.
- A preservation of wisdom and knowledge.
- A way to minimize the impact to a nation.
- *"A process of change through which an individual improves their health and wellness, lives a self-directed life, and strives to reach their full potential".*

Recovery matters to the individual and society

Notes:

Bias in Substance Use Disorder Treatment

Treatment is standardized:
- May attribute signs and symptoms to other older adult issues.
- Treatment plans, approaches, self-help groups, all may provide treatment without understanding the needs of older adults.
- An older adult's own stigmatization of themselves may not be considered or addressed.

Possible solution: APS can research for and suggest Geriatric Specialists/ help clients contact insurance providers for Geriatric Physicians

Notes:

Tools for APS

"If you define the problem correctly you almost have the solution." -*Steven Jobs, Apple Co-founder*

APS professionals have a variety of skills and tools to use when working with someone who has a SUD.
- Soft Skills
- Interviewing Techniques
- Assessments

Notes:

Interviewing Tips

- Given the information you have, plan for times where they are more likely to be sober.
- Approach topic after building rapport and within the context of what they are concerned about.
- Be less assertive in your discussion and more supportive.
- Be gentle and respectful while asking direct questions.
- ***Any discussion on substance use should occur in a conversation about their health and safety.***

- Asking about a substance use issue can be stigmatizing and shaming, which can create defensiveness.
  - Explain your motivation.
  - Communicate they are the expert on their struggles.
  - **Work to meet an immediate need.**

Notes:

CAGE Assessment

CAGE Questions (Adapted to Include Drug Use (CAGE-AID)

(Take out the word "drug" or "alcohol" as appropriate to situation.)

1. Have you ever felt you ought to *cut* down on your drinking or drug use?
2. Have people *annoyed* you by criticizing your drinking or drug use?
3. Have you ever felt bad or *guilty* about your drinking or drug use?
4. Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover (*eye-opener*)?

Notes:

SMAST-G

- First short screening for Older Adults.
- Goal is to identify levels of drinking likely to lead to negative outcomes
- 1 pt for each yes, 2 or more points indicates potential problem

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

Notes:

AUDIT-C

AUDIT-C Questionnaire

1. How often do you have a drink containing alcohol?		2. How many standard drinks containing alcohol do you have on a typical day?		3. How often do you have six or more drinks on one occasion?	
Never	(0 points)	None, I don't drink	(0 points)	Never	(0 points)
Monthly or less	(1 point)	1 or 2	(0 points)	Less than monthly	(1 point)
2-4 times a month	(2 points)	3 or 4	(1 point)	Monthly	(2 points)
2-3 times a week	(3 points)	5 or 6	(2 points)	Weekly	(3 points)
Four or more times a week	(4 points)	7 to 9	(3 points)	Daily or almost daily	(4 points)
		10 or more	(4 points)		

The AUDIT-C is scored on a scale of 0-12 (scores of 0 reflect no alcohol use). In men, a score of 4 or more is considered positive; in women, a score of 3 or more is considered positive. Generally, the higher the AUDIT-C score, the more likely it is that the person's drinking is affecting his/her health and safety.

The AUDIT-C is in the public domain.

Notes:

Person-Centered Interventions and Service Plans

As the APS professional:
- Identifies safety and medical needs
- Assessing the decision-making ability
- Identify referrals for treatment from other providers
- Identifies protective factors

Keep in mind:
- Their perceptions of the situation
- Their strengths
- Their recovery

Notes:

Interventions: Challenges

Challenges:
- Lack of research on treatment, stigmatization and "let them enjoy themselves."
- Lack of self efficacy: the belief they can stop.

Strategies: Brief Interventions
- Express concern
- Provide feedback linking alcohol/drug use and health
- Advise to speak with doctor on possible goals to decrease or eventually abstain from use.
  - Do not advise abstinence or decrease due to potential detox concerns.
- Offer referral to treatment, if appropriate.

(Used with permission by the VA Office of Quality, Safety, and Value)

Notes:

Brief Interventions for APS

Brief interventions focus on: simple screenings, reflective listening and feedback to target motivation

APS can:

- Educate about substance use/misuse and it's impact
- Motivate change by discussing what the person would like to accomplish more of
- Encourage **any** engagement steps that lead towards recovery

Notes:

Types of Talk: Discord, Sustain and Change Talk

- Taken from Motivational Interviewing
- 3 types of talk to listen for:
  - Discord: Interpersonal Disharmony. The client and the APS professional are on different sides.
  - Sustain: Client verbalizes they have no intent to change.
  - Change: Verbalizations that show a client has been thinking about change. It may be very minimal thoughts.

Notes:

Change, Discord and Change Talk: Which One Is It?

A. There doesn't seem to be a point. I've been to rehab so many times in my life. It never worked.

B. Let's just get this done. The real issue is a noisy neighbor that makes a lot of assumptions.

C. I really feel like I should do something about the stomach issues I'm having. I wonder if drinking could be part of the problem.

Notes:

Video: Successful Initial Home Visit

- Listen for change, sustain and discord talk.
- How did the APS professional answer the different types of talk?
  - What were their strengths?
- When discussing the bottles of wine:
  - What were some of their strengths?
  - What are some areas of improvement?
- Is there anything you would have done differently?
  - To assess for risk?
  - To manage the different types of talk?

Notes:

How to Respond to Talk Types

For discord or sustain:

- Validate their perspective.
- Point out what strengths you see.
- Explain you are there to support them and their right to self determination.
- Reflect back what you hear.
  - The client feels heard.
  - Your understanding is clear.

For change:

- Elicit or pull more from them.
- Help them further define
- Continue with steps of Motivational Interviewing

Notes:

Providing Psychoeducation

Help the Person:

- Understand:
  - What equates 1 drink. Rethinking Drinking | NIAAA (nih.gov)
  - The potential for impact of substances on their neurological or medical health.
  - How to discuss medication and substance use with their doctor, including OTC medications and supplements
  - Why organizing medications is helpful.
- Think about why they are using a substance.

Notes:

Encourage Discussion with Primary Care Physician

Older adults living with alcohol use disorder can have a positive response to an intervention from their primary physician and be motivated to change.

APS can help with a follow up on how the appointment went.

- Barriers can be inquired about and addressed.
- If individuals are not following through on tasks, look at the possibility of a barrier rather than assuming lack of motivation.
- Linkage to Geriatric Specialist

Notes:

Trauma Informed Care

The pillars of trauma informed care are:

- Safety: Physical and emotional.
- Choice: Individual choice and control.
- Collaboration: Decisions with shared power.
- Trustworthiness: Task clarity, consistency and interpersonal boundaries.
- Empowerment: Encouraging skill building and problem solving. Substance use disorders are often a work of avoidance. There is work to be done to help the person gain a sense of self efficacy and understand their ability to build skills and to problem solve.

Notes:

Motivational Interviewing: Cycle of Change

- Consider where the client is as you talk to them.
- Understand their ambivalence to change as reasonable.
- Roll with resistance—*don't argue for change*.
- Support self efficacy to help with the confidence gap.

Notes:

Questions to Elicit and Strengthen Motivation

- **Why** might you want to make that change? (You can name the change.)
- **What** could be at stake if you don't change?
- **How** might you go about it in order to succeed? How can I support you?
- **What** are the three best reasons to change? What have you already thought of?
- **Who**, or what could support you?
- **What** next steps could you take? What might be the next thing you would do?

Notes:

Solution Focused

If it isn't broken don't fix it. Don't revise or rearrange what is already working. Empower the client to think and talk about what **is** working.

If it works do more of it: Focus on "Is it effective?" If the client's solutions are effective help them strengthen those strategies.

If it's not working do something different: Does it work? If not, it isn't a solution. Encourage the use of other solutions that could be more effective.

Small steps can lead to big changes: Small manageable steps. Help them move in little steps, provide positive reinforcement—change happens slowly.

No problem happens all the time, there are always exceptions that can be used. Help them remember the times in their life they overcame problems. "Have you had a time in your life when you did not have this problem?"

The future is both created and negotiable: People are architects of their future. Older adults need people who see them as having a viable amount of time to craft their life into what they want it to be.

Notes:

12 Step Groups/ Peer Support

- Focus on:
  - Helping realization there is loss of control
  - Work through steps (safely and with support)
  - Make amends to those they have harmed
  - Living by a set of values that includes service to others.
- Spiritually focused (Higher Power)
- Mutual Aid Groups for support and guidance *(SAMHSA's 10)*
- Different types of groups.
- Sober outings and activities.
- Suggestion: Go to some groups. Read the big book. Know the resources.

AA Meeting Locator - Alcoholics Anonymous Meeting Near Me Search (aa-meetings.com)

Notes:

SMART Recovery/ Peer Support

SMART Recovery (previously Rational Recovery) is an acronym for *Self-Management and Recovery Training*.

- For people who are agnostic, atheist, or do not want to feel dependent on a higher power.
- A science-based approach.
- Avoids labels like "addict."
- Works to gain healthier coping strategies.
- A mutual aid support group that focuses on abstinence.
  - Smaller than 12 Step Groups, however there are online groups.

Notes:

When Substance Use Continues

Why would a person not want to or be unable to work on recovery from a substance use disorder?

What can you do?

- Assess Recovery Capital
  - Human: The individual's strengths
  - Physical: Access to resources
  - Social: Network of support.
    - What cultural capital exists?
- Express concern and leave the door open
- Build on any change talk
- Support lifestyle changes

Notes:

Harm Reduction

Minimizing harm to the substance user for whom abstinence is unrealistic, and/or has not been successful. Recognizes the complexity of reasons for substance use and seeks to start where the client is.

Harm Reduction Strategies for Older Adults

- Alternate drinks with water.
- Delaying start time/number of times used.
- Less harmful substances.
- Increase in other coping skills without abstinence.

Notes:

Development of Protective Factors and Healthy Coping Strategies

- Substance Use Disorder comes with intrusive thoughts
- Successful recovery equates to the successful use of coping strategies other than the substance use.
- A person in recovery must:
  - Create a meaningful sobriety; building activities and relationships that become more important than the substance.
  - Replace the physical Ritual

APS can start small:

- What can be helped with their ADLs and IADLs that increase quality of life?
- Discuss rituals and explore replacements

Notes:

Activity: Identifying Assessments and Interventions

Using same groups and scenarios from previous activity:

1. Refresh your memory of your scenario and individually think of:
   - What assessment(s) and what intervention(s) you would like to use and **why**.
2. Share as a group and come up with at least one you'll report out on.
3. Be creative

Notes:

Notes:

Handout #4- Assessments and Interventions with Scenarios

Scenario #1 (Content Warning)

Shonda: 63 years old, Black woman. Lost her wife 2 years ago in a car accident that they were both involved in. Isolation increased significantly because her wife was "the extroverted one" and she also had survivor guilt and didn't want to be around others. Has fallen several times while walking her dog. She has also been observed multiple times in dirty clothing. A nosy neighbor took a quick look at her Instacart bags when they were dropped off and saw three bottles of Don Julio. They decided to make an APS report out of concern for her falls, appearance and alcohol use.

APS professional: Talked to the reporting party before contacting Shonda. When entering Shonda's home sought to set her at ease by asking her about the artwork displayed throughout the home. Shonda appeared more relaxed after talking about her love of art and felt able to talk about her recent loss. APS professional let her know of his concern about possible substance use at which point Shonda began to cry about the neighbors that harassed her. Full of sympathy for how the neighbors were treating Shonda, he decided to discuss her fall risk while walking the dog and not pursue the possible alcohol issue.

1. Which assessments would you use and why?
2. Which interventions would you use and why?

Scenario #2 (Content Warning)

Charles: 70 years old, White man. Raised by parents who had severe substance use issues. After living through molestation by an extended family member, he started using various substances himself but after many years of use, entered recovery and maintained years of sobriety. Developed osteoporosis and has severe pain, which has been managed by prescription pain pills. When mandated tracking requirements for prescription pills were instituted his doctor cut back on his medications. Charles began buying additional pills illicitly. His use increased and the cost did also. His caregiver became worried about everything they were seeing and filed an APS report.

APS professional: In recovery himself, read the report and felt a little frustrated that the client had relapsed after years of recovery. But—he could help this guy. He just had to remind Charles of what he had done before. The plan unfolded in his head. First, help Charles get a sense of hope. Next, help him understand that things could and would get better. Finally, talk to Charles about that first recovery and get him back on track. Because it sounded like Charles might have been a loner for a while now, the APS Professional decided to not discuss Peer Support Groups and thought their "motivating conversation" was enough.

1. Which assessments would you use and why?
2. Which interventions would you use and why?

Scenario # 3 (Content Warning)

Rainbow, 68 years old White woman. Was proud of being one of the first hippies. Flower power, communal life, love-in's, peace signs, anti-war demonstrations, psychedelic bell bottoms and drugs, she had done it all. She witnessed several friends overdose throughout her teenage years. The drugs she used were mostly experimentation, except for the weed, which she used for years because it helped her manage her anxiety. The smorgasbord of weed that had grown since it was legalized reminded her of the fun and freedom of her teen years. Although she was surprised at how strong the stuff was nowadays. But she'd been smoking forever, she could handle it. The local cannabis shops no longer gave her the "first time member" discounts and Rainbow got behind in her bills and had multiple overdrawn transactions on her bank account. Faye, Rainbow's favorite Bank Teller at the Credit Union Rainbow had been a member of for 30 years, tried to discuss the overdrawn transactions with Rainbow and she blew it off to "just a little habit". Faye reported the concerns to APS.

APS professional: She smiled when she read the report thinking of someone named Rainbow growing up in the 60's/70's. Then she realized the severity. She knew that older adults were more susceptible to mobility hazards, cognitive issues, financial challenges when paired with substance use and that as active as Rainbow is, she'd probably end up getting a DUI someday. She wondered when was the last time the client had seen a doctor? That would be a good place to start. And she also realized she might have some biases after working in APS for so many years and probably needed to check herself on those assumptions. Who knew what the client had done in her life. And what she still might want to do. Was the cannabis use getting in the way of anything?

1. Which assessments would you use and why?
2. Which interventions would you use and why?

Scenario #4 (Content Warning)

Gonzalo, 83 years old Hispanic man. With he and his wife being blessed with six children and being the primary breadwinner, working hard his entire life, he'd earned an early retirement. Finances were tight but he was careful. He and his beloved Areceli had lived quietly and happily, enjoying the grandchildren and their time together. She had passed away, in their home, about 10 years ago at age 67. He'd adjusted to her loss, but now, approaching 85, he seemed to miss her more. His kids loved him, but they were busy. His back injury kept him from using his hands; doing the building and repairing he loved. His time ticked by too

slowly. He needed more in his life. He liked feeling busy and happy. Gonzalo kind of stumbled into using his pain medications for more than physical pain. First, he realized they made time slip away. He started using more than prescribed, which led to making excuses about why the pills were gone so quickly. That didn't work to well so then he started trying to get more pills before time for refills by exaggerating the pain when he talked to the doctor to get an increase in strength. One of his sons caught got suspicious when Gonzalo started neglecting his house, eating poorly and isolating away from his family until it became very noticeable. Gonzalo denied everything and his son, feeling scared about the father changing in front of him, phoned in a concern of self-neglect.

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1. Which assessments would you use and why?
2. Which interventions would you use and why?

P-I-E

P – Priceless piece of information.

What has been the most important piece of information to you today.

I – Item to implement.

What is something you intend to implement from our time today?

E – Encouragement I received.

What is something that I am already doing that I was encouraged to keep on doing?

Notes:

Summary:

Thank you for being present for the discussion of:

- The changing population of older adults with substance use disorders.
- Substances commonly used.
- Assessment and treatment.
- Interventions.

Questions?

Be the one who tells the person struggling with a substance use disorder that there is a way out.

Notes:

Thank You!

We envision a world where
the quality of life for individuals, organizations, and communities
is transformed into a healthier place.

Notes:

Resources

The following resources are current as of November 3, 2023:

- Link from SAMHSA to Center of excellence, which has six learning modules on LGTBQ+ issues.

  Center of Excellence on LGBTQ+ Behavioral Health Equity E-Learning Modules | SAMHSA

- Guidelines for safe drinking, FAQ's and tools.

  Help Links and Resources From Rethinking Drinking | NIAAA (nih.gov)

- YouTube video on LGBTQ+ Older Adults

  Animated Short on Providing Equitable and Affirming Care to LGBTQ+ Older Adults - YouTube

- SAMHSA: Information on Recovery

  Recovery and Recovery Support | SAMHSA

  TIP 35: Enhancing Motivation for Change in Substance Abuse Treatment

- APS TARC: Trauma Informed Services

  Trauma-Informed Approach for Adult Protective Services (acl.gov)

- Alcoholics Anonymous Location Finder

  AA Meeting Locator - Alcoholics Anonymous Meeting Near Me Search (aa-meetings.com)

- Narcotics Anonymous Meeting Locater

  Find Narcotics Anonymous Meetings

- SMART Recovery—Self Directed, Science Based Recovery

  SMART Recovery

- Geriatric Professionals Locator
  Find a Geriatrics Healthcare Professional | HealthInAging.org

- Veterans Support for Substance Use

  Substance Use Treatment For Veterans | Veterans Affairs (va.gov)

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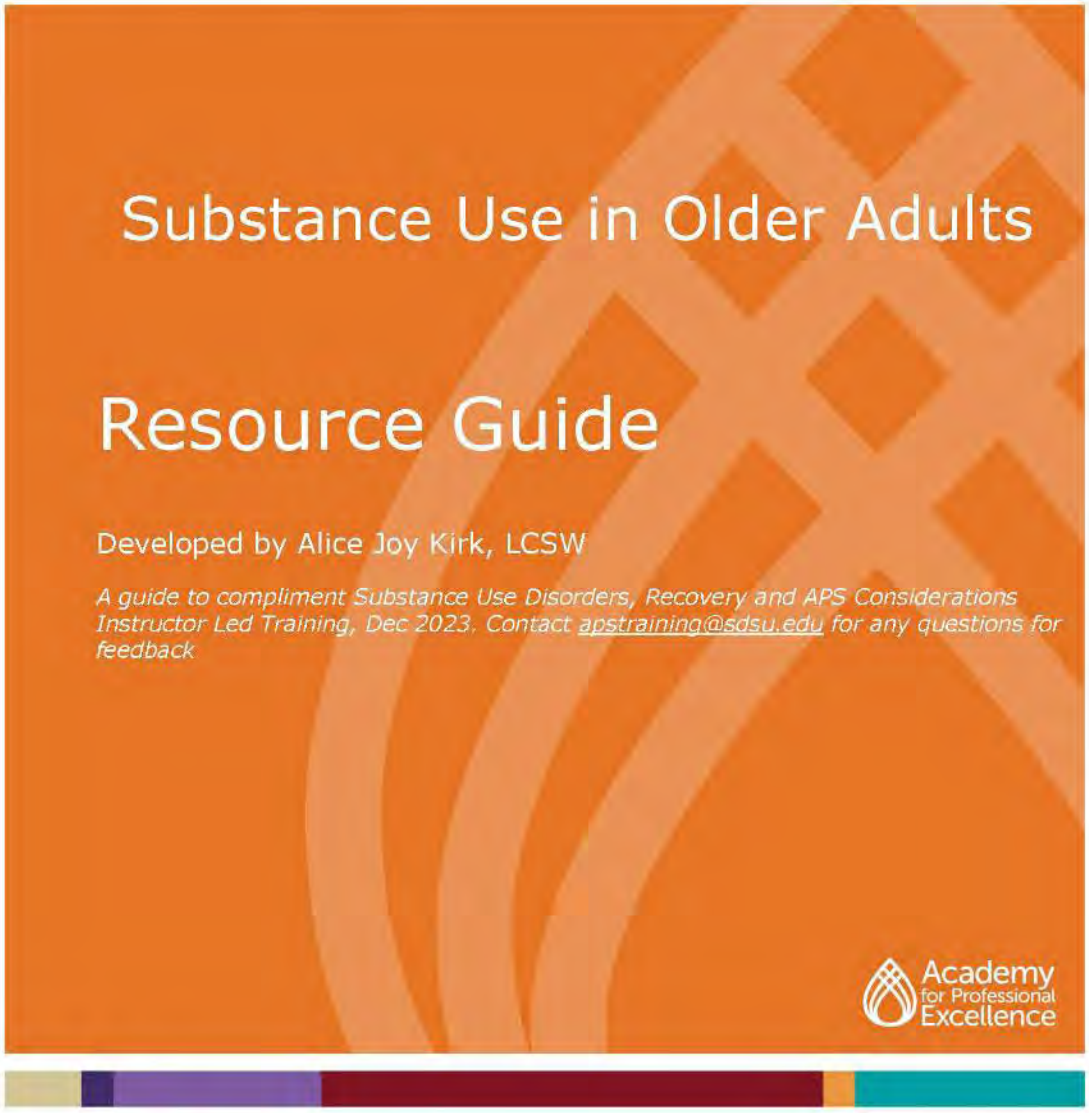
Appendix



APSWI
Adult Protective Services Workforce Innovations

Substance Use in Older Adults Resource Guide

Objective:

This resource guide is created to be a both a guide in understanding older adults and substance use and having the resources to help them. It supports the concepts and learning from the *Substance Use Disorders, Recovery and APS Considerations* Instructor Led Training.

It is to provide information to APS professionals about the most commonly used substances, signs of substance use, and impacts of substance use. This will provide, or add, to one's foundational knowledge and allow for more complete service provision. It is not meant to be used clinically.

This guide also provides definitions, information and research that can be used in providing psychoeducation to older adults. Psychoeducation with older adults has been proven to be effective in behavior change. Having a knowledge base about substance use and older adults is an important resource on its own for those working with older adults who have high risk drinking or possible substance use disorder.

There are resources and links to tools that will help APS professionals build their tool box that helps them do their job.

Please use this resource in a way that benefits you and the people you work with.

Contents:

Content Warning:

We recognize that APS work is both challenging and rewarding and APS professionals are whole human beings who have their own experiences before and during APS work. Information and concepts in this guide may activate feelings based on personal or professional experiences, including vicarious trauma and we encourage everyone to do what they need to do in order to safely engage in this material.

Alcohol Use & Older Adults

Method of Ingestion:

- Oral: time of impact depends on weight, gender, and stomach contents.

Impact of Alcohol:

- Increase in dopamine production.
- Increase in sociability.
- Dulls perception of pain.
- Warms body
- Sleepiness

Did you know...

"Recent studies show that although the vast majority of those with an Alcohol Use Disorder see their doctors regularly, for a range of issues, fewer than 1 in 10 ever receives treatment for drinking." (Fagbemi, 2023)

Signs of Alcohol Abuse:

- Drinking as a response to emotions.
- Drinking quickly, drinking all the time, or having multiple drinks in one setting.
  - Binge Drinking = 5 drinks or more in one setting.
- Being secretive about, or hiding their drinking.
- Injuries from loss of coordination.
- Isolating, or giving up activities previously valued.
- Decline in self-care/home care.
- Changes in memory.
- Legal, financial or social problems.
- Malnutrition.

Medications and Therapeutic Interventions for Alcohol Use Disorder:

- Benzodiazepines are the mainstay to manage alcohol withdrawal symptoms
- Two medications are used for reduction of cravings and relapse prevention. For optimal success they should be paired with behavioral therapy:
  - Naltrexone: Not recommended for those who need opiates for pain management as it blocks the opiate receptors. It is also contraindicated for those who have liver impairment.
  - Acamprosate can be used to reduce cravings in for those who use opiates for pain management or have impaired liver function. Patients must have adequate renal function.

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- Disulfiram: Blocks enzyme that breaks down alcohol and creates acute sensitivity to alcohol. Can damage liver and has been shown to have adverse effects in older adults. Should only be used in those willing to have complete abstinence.
- Multiple studies have found brief interventions, including psychoeducation, are effective in helping older adults decrease drinking.

Withdrawal from Alcohol: (Requires Medical Detox)

Older adults are at higher risk for severe alcohol withdrawal symptoms and need closer monitoring, particularly if there is a history of delirium tremens and seizures.

- 1st Stage
  - 6-12 hours after abstinence
  - Mild symptoms
  - Changes in blood pressure, heart rate, breathing
  - Nausea and vomiting
- 2nd Stage
  - After 12 hours of abstinence
  - Alterations in perception, such as visual, auditor or tactile hallucination
- 3rd Stage
  - After 24 to 48 hours of abstinence
  - Can have tonic-clonic seizures
  - Delirium Tremens
- Other Symptoms of Withdrawal:
  - Agitation/Anxiety
  - Confusion (likely in older adults)
  - Sweating
  - Insomnia
  - Increased heart rate

Development of Alcohol Use Disorder

- Those who developed AUD before age 60:
  - Have a more severe course of the illness
  - Predominately Male
- Those who developed it after age 60:
  - Milder clinical picture
  - Predominantly women
  - Risk factors for onset are chronic pain, recent stressful life event, susceptibility to mood or anxiety disorders

Effects of excessive Alcohol use:

- Disruptions in mood and behavior, including depressive disorders
- Mobility issues
- Difficulty thinking clearly
- Weakened immune system
- Atrophy and scarring of pancreas/Acute Pancreatitis
- Higher rate of oral, pharyngeal/laryngeal, colorectal, hepatic and esophageal cancers
- Cirrhosis
- Fatty Liver
- Vitamin deficiencies. (B vitamins in particular)
- Gastrointestinal (GI) problems/GI hemorrhage

Depression and Alcohol Use

Depressive disorders are the most commonly diagnosed psychiatric illness in older adults.

Depression is often underrecognized and underreported.

Alcohol use or dependence can be a first indication of a depressive disorder.

Alcohol use can initially decrease emotional distress but the long-term impact is to increase it.

Depression is a common risk factor for suicide. Alcohol use is a main risk component.

Other risk factors for suicide in older adults with depression:

- Male
- Physical Pain
- Bereavement
- Social Isolation
- Financial problems
- Lack of access to treatment
- Increase in psychotropic drugs

Prescribed for:

- Chronic Pain
- Glaucoma
- Seizures
- Chron's Disease
- HIV/AIDS
- ALS
- Nausea
- Multiple Sclerosis

Impact of Cannabis Abuse:

Research is limited. Current research suggests potential long-term impacts are:

- Grey matter decline in frontal and precentral cortex
- Reduction in performance on tasks that involve executive functions
- Grey matter decline in hippocampus corresponding with memory impairment
- Coronary Heart Disease
- Individuals with neurological disorders can face a stronger impact and more problems
- Cannabis use may be associated with Alcohol Use Disorder, nicotine dependence and misuse of prescription drugs.

Withdrawal from Cannabis: (24-48 hours after cessation)

- Irritability
- Anger
- Anxiety
- Insomnia/sleep disturbance
- Loss of appetite
- Depression

Note: There is no withdrawal from products that have CBD with THC removed.

Opiates/Narcotics & Older Adults

Method of Ingestion:

- Swallowed
- Smoked
- Sniffed
- Injected

Impact of Opiates/Narcotics

- Drowsiness and Stupor
  - Inability to concentrate
- Relieves pain
- Stimulates reward regions and gives a sense of euphoria
- Creates respiratory slowing
- Reduces tension and anxiety
- Creates constipation

Signs of Opiate Abuse

- Doctor and/or Pharmacy Shopping
  - Medications frequently get "spilled/lost/taken."
- Increase in Emergency Room visits due to falls/overdose.
- Driving impairment/motor vehicle accidents.

Prescribed For

- Moderate to severe pain

Commonly Prescribed Opiates

*Codeine *Morphine * Oxycodone and acetaminophen (Percocet) * Fentanyl

*Hydromorphone (Dilaudid) *Hydrocodone and acetaminophen * Buprenorphine (Belbuca, Butrans)

*Oxycodone (Oxaydo, Roxicodone, Roxybond) * Hydrocodone extended release (Hysingla ER)

*Methadone (*Methadone HCl Intensol*) *Morphine extended release (MS Contin)

*Tapentadol extended release (Nucynta ER). *Oxycodone extended release (OxyContin, Xtampza ER).

Risk Factors for Opiate/Narcotic Abuse

- Chronic Pain
- Mental Health Issue, Depressive and Anxiety disorders, PTSD
- Alcohol and other substance use disorders
- Bereavement
- Social Isolation
- Functional Decline

- Women are at risk of misusing opioids due to emotional stressors
- Men tend to abuse opioids for legal and problematic behavioral issues

Withdrawal from Opiates/Narcotics

- Restlessness
- Involuntary Leg Movement
- Insomnia
- Diarrhea
- Vomiting
- Bone Pain

Consequences of excessive Opiate/Narcotic Use

- Impaired Motor Coordination/Dizziness/Falls
  - Increased Emergency Room Visits
- Impaired Cognitive Functioning
- Chronic Constipation
  - Associated with fecal impaction & bowel perforation.
- Slowed respiration which can result in, Hypoxia, inadequate oxygen reaching the brain. This can result in coma, brain damage, or death.
- Elevated risk of Cardiovascular events; myocardial infarctions, stroke, heart failure

FYI . . .

It can be very difficult for those who have chronic pain to accept they have an opiate use disorder. If medications are decreased by their physician some will prefer to find other methods to procure opiates including illicit (street) purchase. Heroin is chemically similar; it produces the same effect and can be cheaper.

Benzodiazepines & Older Adults

Method of Ingestion

- Oral (Pills)
- Suppositories
- Snorted
- Smoked

Prescribed For

- Sleep Disorders
- Panic and Anxiety Disorders
- Alcohol Withdrawal

Commonly Prescribed Benzodiazepines

*Triazolam (Halcion) short acting	*Clonazepam (Klonipin) long acting
*Lorazepam (Ativan) short acting	*Alprazolam (Xanaz) short acting
*Flunitrazepam (Hypnodorm) long acting	* Diazepam (Xanax) long acting
* Nitrazepam (Alodorn) long acting	* Bromazepam (Lexotan) mid acting
* Clozbazam (Frisium) long acting	* Temazepam (Normison) short acting
* Oxazepam (Alepam) short acting	

Impact of

- Relaxed mood
- Ability to sleep
- Increased risk of falls for multiple reasons: increased reaction time, disrupted balance, sedation and impaired vision

Signs of Benzodiazepine Abuse

- Doctor and/or Pharmacy Shopping
  - Medications frequently get "spilled/lost/taken"
- Increase in Emergency Room visits due to falls/overdose
- Driving impairment/motor vehicle accidents
- Excessive sedation: Constant dozing off or sleeping

Withdrawal from Benzodiazepines

- Increased Heart Rate
- Hand trembling
- Insomnia
- Anxiety

- Vomiting
- Seizures (20%- 30%--if abruptly stopped)

Consequences of excessive Benzodiazepine Use

- Older Adults have the highest risk of adverse impacts
- Cognitive Impairment
- Delirium, **a serious and sudden change in mental abilities**
  It results in confused thinking and a lack of awareness of someone's surroundings

Note: Benzodiazepines should only be stopped under a doctor's care and with a tapering off plan.

Methamphetamine & Older Adults

Method of Ingestion

- Oral (pills)
- Snorted
- Smoked
- Injected

Prescribed For

- Attention Deficit Disorder
- Obesity (Desoxyn)

Impact of

- Releases high levels of Dopamine into body
- Decreased Appetite
- Increased Wakefulness
- Increased Activity

Signs of Methamphetamine Use

- Extreme weight loss
- Severe dental issues
- Skin picking/open sores
- Sleeping problems
- Paranoia/Delusions
- Violent behavior
- Confusion/Memory Loss
- Elevated body temperature

Withdrawal from Methamphetamine

- Depression
- Anxiety
- Symptoms of Psychosis
- Intense drug cravings
- Excessive sleep or appetite

Consequences of excessive/long term Methamphetamine Use

- Cardiovascular disease
- Hemorrhagic stroke
- Cellulitis and abscesses around injection sites
- Infective endocarditis and HIV
- Damages dopamine producing cells in brain after prolonged exposure, even in small amounts

- Associated with symptoms of psychosis, such as paranoia or delusions, which can exacerbate cognitive decline

Drug Scheduling

What is Drug Scheduling?

Substances that are considered to have high potential for addiction or abuse are scheduled under the Controlled Substances Act. The schedules are based on their currently accepted medical use, their abuse potential, and the ability to cause dependence.

Schedule I

- *No currently accepted medical use and high potential for abuse.*

Schedule II

- *Drugs with a high potential for abuse and can potentially lead to severe psychological or physical dependence.*

Schedule III

- *Drugs with moderate to low potential for physical or psychological dependence. Less than Schedule I or II, more than Schedule IV.*

Schedule IV

- *Substances, or chemicals defined as drugs with low potential for abuse and risk of dependence.*

Schedule V

- *Substances or chemicals defined as drugs with lower potential for abuse than schedule IV and consist of preparations containing limited quantities of certain narcotics.*

Why does Drug Scheduling Matter in APS Practice?

Drug Schedules help shape public perception of substance use and risk. These perceptions do not always fit older adults. Awareness of drug schedules can help provide foundational knowledge as one works with the older adult population. For example:

- *Alcohol* is the most common substance use disorder diagnosed in older adults, and alcohol impacts older adults more severely. Alcohol is not a scheduled substance; however, it does not indicate low risk for use and dependence. Risk should be considered by any professional assessing an older adult.
- *Benzodiazepines* are a Schedule IV drug with "low potential for abuse and risk of dependence." It is also a substance identified as putting older adults at risk due to the impact on cognition and mobility. The American Geriatrics society has recommended Benzodiazepines are avoided for older adults. At this time older adults are widely prescribed these medications.

- *Cannabis* is a schedule I drug. This means there is no current accepted medical use and high potential for abuse. Because Cannabis is being prescribed and there is ongoing research due to the legalization in many countries and states this will change. *Reminder: All clients using cannabis should be encouraged to talk to their doctor.*

Definitions

Ageism: stereotypes (how people think), prejudice (how people feel) and discrimination (how people act) towards others or selves based on age. Can be individual, institutional or systemic. World Health Organization states 1 in 2 people are ageist.

At Risk Use (Alcohol): More than 7 drinks a week, or mixing drinking with medications. A style of drinking that is not sustainable without causing health problems.

Baby Boomers: people born between 1946-1964 (now in their 60's-70's).

Binge Drinking: five or more drinks at one time. Ex. One bottle of wine has five drinks.

Brain Blood Barrier: a semipermeable and extremely selective system in the central nervous system. It plays a vital role in regulating the transport of necessary materials for brain function, furthermore, protecting it from foreign substances in the blood that could damage it. In aging, this barrier becomes more permeable.

Complicated Grief: When something interferes with the adaptation to loss of a significant person/animal. When this happens, acute grief can persist for very long periods of time and the person feels intense emotional pain. Complicated grief can be a risk factor for older adult substance use.

Delirium Tremens: Multiple symptoms when person dependent on alcohol stops drinking. Symptoms include: shaking, sweating, shivering, irregular heart rate. Less common symptoms are high body temperature, seizure and hallucinations.

Hyper polypharmacy: Use of 10 or more drugs at a time, prescribed or non-prescribed.

Nocturia: waking up more than one time a night to urinate. Common outcome of Polyuria. Can lead to impaired sleep, nocturnal falls, incontinence, daytime sleepiness.

Polypharmacy: Use of more drugs than clinically indicated. Use of 4 or more drugs at a time.

Polyuria: excreting more than 3 liters of urine a day.

Problem Use (Alcohol): use of substances that has already resulted in adverse medical, psychological or social consequences (impaired functioning). Medication misuse; skipping doses, borrowing medications, taking higher doses than prescribed fits into this category. Small amounts of drinking paired with contraindicated medications fits here.

Recovery (SAMHSA): A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

Substance Use Disorder: a cluster of cognitive, behavioral and physiological symptoms with the continued use of the substance despite those symptoms.

Tonic-Clonic Seizure: Also known as a grand mal seizure. Tonic phase is loss of consciousness. Muscles suddenly contract. Clonic phase is when muscles alternately contract and relax leading to convulsions.

What medications can cause polyuria & nocturia?

*Alpha-blockers *Antihistamines *Diuretics
*Calcium channel blockers *Diabetes medications
*Antipsychotics *Decongestants *Opioids
*Mood stabilizers *Tricyclic Antidepressants

Resources

- Free Booklet: Rethinking Drinking: Alcohol and Your Health (left hand side of page) This resource has **a lot** of information. A PDF is provided.
  - What's a Standard Drink Measurement? - Rethinking Drinking | NIAAA (nih.gov)
- Drinking Tracker Cards: printable
  - Alcohol Consumption Tracker - Rethinking Drinking | NIAAA (nih.gov)
- Planning For Change: A printable template
  - Alcohol Reduction Plan Template - Rethinking Drinking | NIAAA (nih.gov)
- Drug Scheduling
  - dea.gov
- Substance Identification
  - Controlled Substances- Alpha Order (usdoj.gov)

SAMHSA Resources

- Home - FindTreatment.gov (below resources and more)
  - 988 suicide and crisis hotline—call or text 988
  - National Helpline—treatment and referral information 24/7—1800-662-4357
  - Disaster Distress Helpline—1-800-985-5990
- Online Book
  - TIP 26: Treating Substance Use Disorder in Older Adults | SAMHSA Publications and Digital Products
- SAMSHA Advisory—good information and a link to tip 35, a digital book on using motivational interviewing.
  - USING MOTIVATIONAL INTERVIEWING IN - Advisory 35 (samhsa.gov)
- Substance Use information and resources for Lesbian, Gay, Bisexual, Transgender, Queer and Intersex.
  - Lesbian, Gay, Bisexual, Transgender, Queer, and Intersex (LGBTQI+) | SAMHSA
- Link to Tip 63: Medications for Opioid Use Disorder
  - TIP 63: Medications for Opioid Use Disorder - Full Document | SAMHSA Publications and Digital Products

12 Step/Support Groups

- Alcoholics Anonymous Location Finder
  - AA Meeting Locator - Alcoholics Anonymous Meeting Near Me Search (aa-meetings.com)
- Narcotics Anonymous Meeting Locater
  - Find Narcotics Anonymous Meetings
- SMART Recovery—Self Directed, Science Based Recovery
  - SMART Recovery
- Veterans Support for Substance Use
  - Substance Use Treatment For Veterans | Veterans Affairs (va.gov)
- Alanon (For Families)
  - Find an Al-Anon or Alateen Face-to-Face, Phone, or Online Meeting

Geriatric Professionals Locator
Find a Geriatrics Healthcare Professional | HealthInAging.org

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