Substance Use, Recovery and APS Considerations

Instructor Led Training (Virtual or In-Person)

TRAINER 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

We are pleased to welcome you to **Substance Use, Recovery and APS Considerations Trainer 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

cdss.ca.gov/Adult-Protective-Service

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

https://www.cwda.org/about-cwda

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

Ralph Pascual, Human Services Administrator I, Los Angeles County,
Rachel Vo, Senior Social Services Supervisor, County of Orange
Jessica Burke, Staff Development Officer, Riverside County
Nancy McPheeters, Training and Development Specialist, San Bernardino County
Penny Jacobo, APS Supervisor, San Diego County
Whitney Barnes, Social Work Supervisor, Santa Cruz County
Mary Grace Juanta, Sr. Adult Protective Services Specialist, San Diego County
Quatana Hodges, Social Services Supervisor 1, County of Orange

Committees

National Adult Protective Services Association (NAPSA) Education & Development Committee

Curriculum Developer

Alice Joy Kirk, LCSW

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How to Use This Manual

This curriculum was developed as a virtual **4.5 hour workshop** using the Zoom platform, paying close attention to virtual training best practices. It can be tailored to a different virtual platform (WebEx, GoTo Training, etc.), if necessary. It may also be trained in-person by modifying activity and engagement prompts as necessary. When possible, virtual and in-person prompts are given.

The Participant Manual should be sent ahead of time as a fillable PDF if using Adobe Acrobat or to allow participants to print a hard copy.

- Actions which the trainer takes during the training are written in **bold**
- *Trainer notes are italicized*

Use of language: Throughout the manual, staff is used most often to describe supervisees or units/teams. The broader term (APS) Professional is also used to denote individual staff who may go by various titles. The term client is used most often to describe the individual at the center of the APS investigation. However, if concept or material was directly quoted from copyrighted material, another term may be used.

He and she have been replaced with the gender-neutral they throughout this manual, unless quoted from copyrighted material. This should not be thought of as plural persons, but rather a gender-neutral term describing all humans.

Customizing the Power Point:

This manual is set up so that the trainer script/ background material is on the same page as the accompanying PowerPoint slide. **Hide a slide instructions**: 1. On the Slides tab in normal view, select the slide you want to hide.

On the Slide Show menu, click Hide Slide. The slide number will have a line through it to show you have hidden it.

NOTE: The slide remains in your file even though it is hidden when you run the presentation.

The course outline, provided in the next section of this manual, is the class schedule used for development of this curriculum. It can be used to help determine how much time is needed to present each section. However, times will vary based on the experience and engagement of the audience.

Trainer Guidelines

It is recommended that someone with a strong background in Behavioral Health facilitate this virtual workshop. Co-facilitation with an APS trainer or supervisor is encouraged.

Suggestions for virtual training when possible:

- Have a moderator or co-host who can primarily focus on the virtual aspects of this training (e.g., monitoring chat box, launching polls, assigning breakout groups, monitoring participant reactions, etc.).
- Test out the use of the breakout room feature prior to conducting this training.
- Log in at least 30 minutes prior to the training to ensure the virtual classroom is fully functioning and that you are comfortable navigating it.
- Your equipment and platform may dictate how you do some activities or discussion. There are times you may not be able to see everyone's faces, names or reactions (thumbs up, mute/unmute, etc.). There is a need for both verbal discussion and chat discussion. At such times, the moderator will fill a critical role monitoring those features you cannot. Practice during a run through how you will use the various functions for each section.
- The optimal size for this virtual training is 25-30 participants.

Teaching Strategies	The following instructional strategies are used: o Lecture segments o Interactive exercises (e.g., breakout groups, chat box discussion, video demonstration, polling activities) o Question/answer periods o PowerPoint Slides
Materials and Equipment	**The following materials are provided and/or recommended:** o Trainer Manual o Participant Manual (fillable PDF) o PowerPoint Slides o Headset with microphone Computer

Virtual Training Tips

Training and facilitation have always been an art. Virtual training is no exception. Below are some helpful tips to remember and implement when training in a virtual environment.

- Assume nothing.
  - Do not assume everyone has the same knowledge or comfort level with technology or has access to equipment like printers, video camera, headsets or even reliable Wi-Fi.
- Distractions are everywhere.
  - Participants have greater access to distractions (email, phone, others at home) which can take their focus away from the training. Therefore, explain everything and summarize before asking participants to complete an activity and check for clarification.
- Over explain when possible.
  - The virtual room doesn't allow for participants to see everything you're doing as they can in-person. Share as you navigate the virtual environment. If you are silent while looking for something or finding a screen, they may think something is frozen.
- Mute with purpose.
  - "Mute all" function can help ensure we don't hear conversations we're not supposed to. However, it can also send a message to the participants that they are a passive participant and may not make them feel comfortable taking themselves off mute when you want them to speak.
- Two screens can be a lifesaver.
  - This allows you to move your chat box or participant gallery view away from your presentation so you can see more of what's going on.
- Rely on practice, not luck.
  - Winging it during an in-person training or facilitation may work from time to time, but doesn't work in the virtual environment. In addition to covering the content, you have to manage all of the technology issues, learning styles in a virtual room, and it will show if you're not prepared.
- Bring the energy.
  - As trainers, we are no strangers to being "on," standing and moving around. However, some of the body language, subtle nonverbal skills we relied on the in-person training room do not translate well in the virtual environment. While this may make you more tired, it's

important to up your enthusiasm, voice, and presence in order to engage with attendees.

- Be mindful of your space.
  - Training virtually brings an entirely new component of what we're willing to share with others. Learners can get distracted with what's in your background, whether what is physically there or if you set your video to use a virtual background.
  - It's important to reflect on questions of privilege, diversity and equity when thinking of your training space.

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	*5-7 min.*
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	*25 min.*
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	*30 min.*
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		*3 min.* *15-20 min.*
Activity #5- Identifying Appropriate Assessments and Interventions to scenarios (*individual, breakout groups)*	Handout #4	*30 min.*
WRAP UP AND EVALUATIONS		**15 minutes**

• Summary • Activity #6-PIE *(individual, large group)* • Evaluations		*7 min*
TOTAL (EXCLUDING BREAKS)		**4.5 hours**

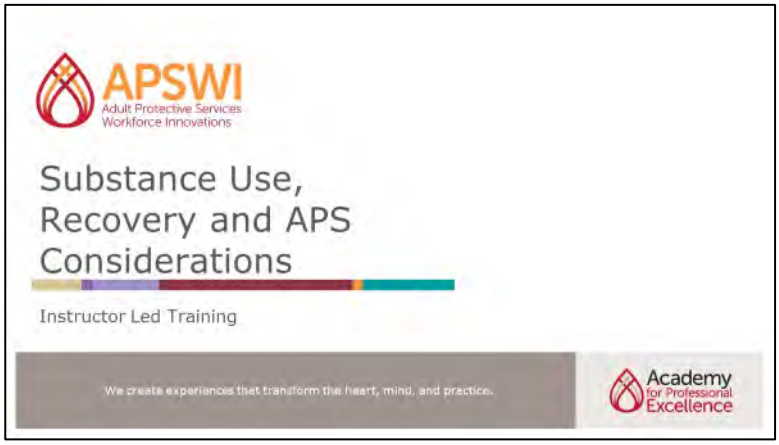
Welcome, Introductions and Course Overview

Time Allotted: 20 minutes

Associated Objective(s): NA

Method: Poll, Large Group Discussion

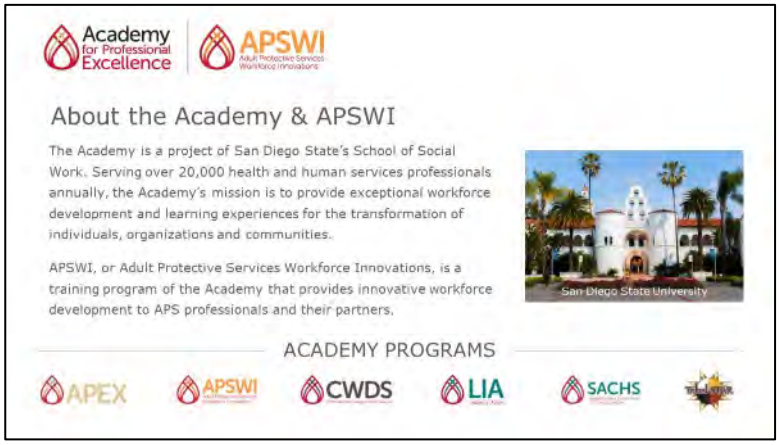
Slide #1: Welcome



Welcome participants and allow everyone to settle in.

Ask participants to sign in or type names, titles, and counties into chat box.

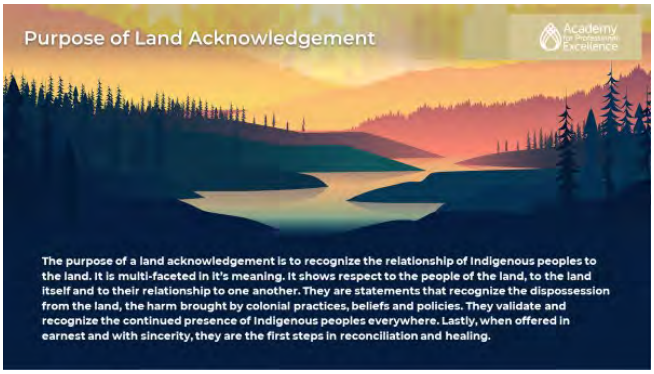
Slide #2: About the Academy and APSWI

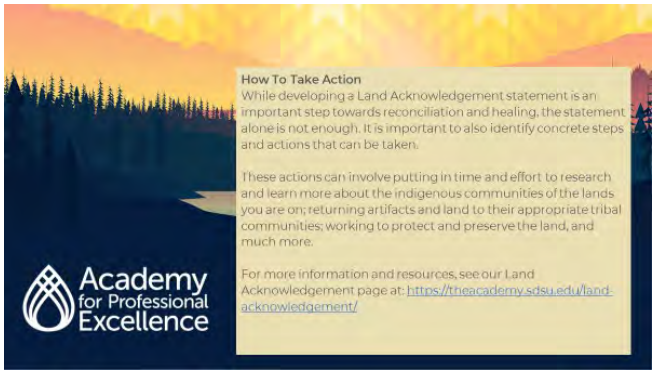


Explain that the Academy for Professional Excellence is a project of San Diego State School of Social Work. Its mission is to provide exceptional workforce development and learning experiences for the transformation of individuals, organizations, and communities.

Explain that Adult Protective Services Workforce Innovations (APSWI) provides innovative workforce development to APS professionals and their partners. APSWI is a program of the Academy for Professional Excellence along with others listed on the slide.

Slide #3-5: Land Acknowledgement





Trainer note: These slides incorporate a national land acknowledgment to honor the land that anyone who access the materials is on. When training, **insert** the land you're training from.

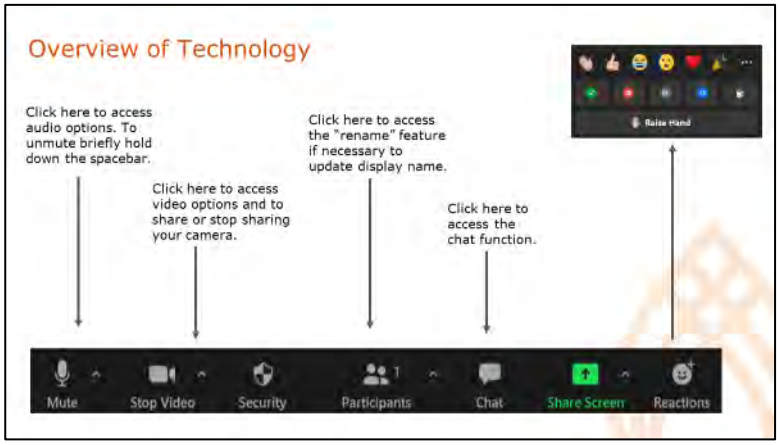
Share:

- Slide #3- The purpose of a land acknowledgement is to recognize the relationship of Indigenous peoples to the land. It is multi-faceted in its meaning. It shows respect to the people of the land, to the land itself and to their relationship to one another. They are statements that recognize the dispossession from the land, the harm brought by colonial practices, beliefs and policies. They validate and recognize the continued presence of Indigenous peoples everywhere. Lastly, when offered in earnest and with sincerity, they are the first steps in reconciliation and healing.

- Slide #4- For millennia, hundreds of Tribal nations have been a part of this land. This land has nourished, healed, protected, and embraced them for many generations in a relationship of balance and harmony. As members of the Academy community, we acknowledge this legacy. We promote this balance and harmony. We find inspiration from this land; the land of the original inhabitants of this Nation. Find the tribe(s) in your area: https://native-land.ca/

- Slide #5- **How To Take Action.** Making a statement isn't enough. It is important to also identify concrete steps and actions that can be taken to support Native American people including land back efforts which are necessary steps towards reconciliation and healing. These actions can involve putting in time and effort to research and learn more about the indigenous communities of the lands you are on; returning artifacts and land to their appropriate tribal communities; working to protect and preserve the land, and much more. **Take Action: Land Acknowledgment** PDF https://acrobat.adobe.com/link/track?uri=urn:aaid:scds:US:ddc71826-b7e8-30b5-bbca-87cf89428c64

Slide #6: Overview of Technology/Housekeeping



Welcome participants to class. **Introduce** yourself by name, job title, organization, and qualifications as the trainer for this topic.

Review the following housekeeping items:

- Respect everyone's opinions, each other's time, and speakers
- Timeliness- be on time back from breaks.
- Confidentiality- at any point when we discuss real cases, do not share names or identifying information.

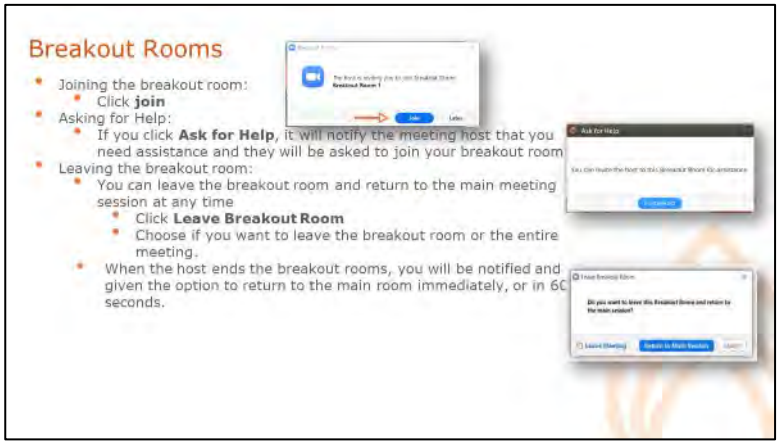
Virtual Additions:

- Always keep your audio on mute, unless instructed otherwise.
- Use the raise hand option to ask questions.
- Post any questions in the chat box that need additional clarification or information.
- Use of camera
  - Hide self-view is an option on Zoom
- Reaction tabs

Share the following content warning for today's content:

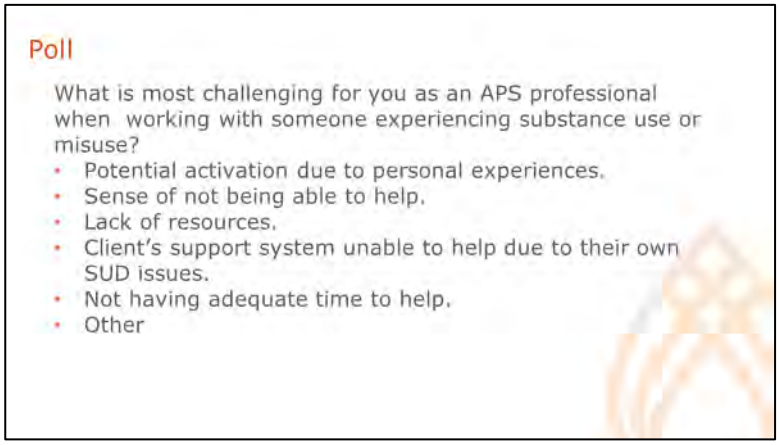
We recognize that APS work is both challenging and rewarding and that APS professionals are whole human beings who have their own experiences before and during APS work. Content and discussion today may activate or trigger difficult to manage feelings based on your own personal or professional experiences. This includes vicarious trauma, and we encourage everyone to do what they need to in order to safely engage in the training today.

Slide #7: Breakout Rooms



Review breakout room functions.

Slide #8: Poll & Activity #1



Activity #1- Connecting Together (5-7 minutes)

Individual, Large Group

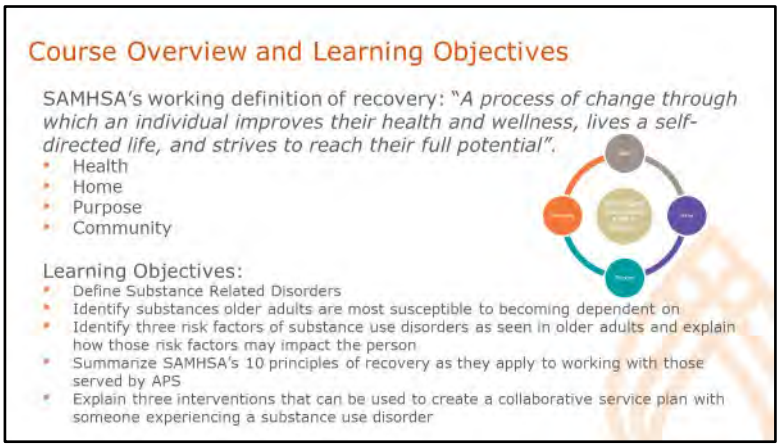
Poll: What is most challenging for you as an APS professional when working with someone experiencing substance use or misuse?

- 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

Share poll results and **ask** participants to share their thoughts on their answers (e.g. For those who stated sense of not being able to help, tell me more about that).

Trainer note: If virtual, depending on comfort level of participants, this can be conducted as a poll by raising hands or instead asking for participants to think about these and if anyone is willing to share, to please do.

Slide #9: Course Overview & Learning Objective



Trainer note: this slide is animated to first review the course overview and then the learning objectives.

Course Overview:

- **Share** As we discuss substance use and recovery, we'll want to keep in mind SAMHA's working definition of 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".
- **Explain**: SAMSHA proposes that there are "four major dimensions that support a life in recovery":
    - Health: Healthy choices that support emotional and physical wellbeing
    - Home: A stable and healthy place to live.
    - Purpose: Meaningful daily activities and the ability to participate in society.
    - Community: Relationships that provide support, friendship, love and hope.
- Substance Use Disorders (SUD) can have a negative impact on the quality of human life. APS strives to help people reduce negative impacts by replacing harmful or unsafe behaviors with tools to create a more fulfilling quality of life. Working with people who experience substance use disorders is an opportunity for APS to engage in those goals.

- Using this definition and these dimensions in mind, today's content will include:
    - Introduction to substance use including types of substances most likely to be used by older adults and risk factors
    - Treatment Options and SAMHSA's 10 Guiding Principles
    - Assessments that APS professionals can use in their practice.
    - Interventions that can be used to build rapport and help the client consider what they want past substance use.

Learning Objectives:

Review 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
- Explain three interventions that can be used to create a collaborative service plan with someone experiencing a substance use disorder

Explain: What substances will we cover in this presentation, and what will we not cover.

- We <u>are</u> going to discuss alcohol, cannabis, prescription & illicit drugs—which are typically opioids and methamphetamine.
- We are <u>not</u> going to discuss tobacco even though tobacco is the most common SUD-related cause of death

We will <u>not</u> discuss any *behavioral addictions*, such as gambling disorder, which is classified in the DSM as a behavioral addiction due to the fact it activates the brain's reward system in a way substances do. Other possible behavioral addictions, such as sex, or exercise have not been researched enough to include in the DSM, and will also not be discussed.

Introductions to Substance Use and Older Adults

Time: 85 minutes

Associated Objective:

- 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

Method: Lecture, Q&A, Large Group Discussion, Chat and Breakout room.

Slide #10: The Population We Serve

Share the quote on the slide: "Where you stumble, there lies your treasure." (Joseph Campbell, Writer).

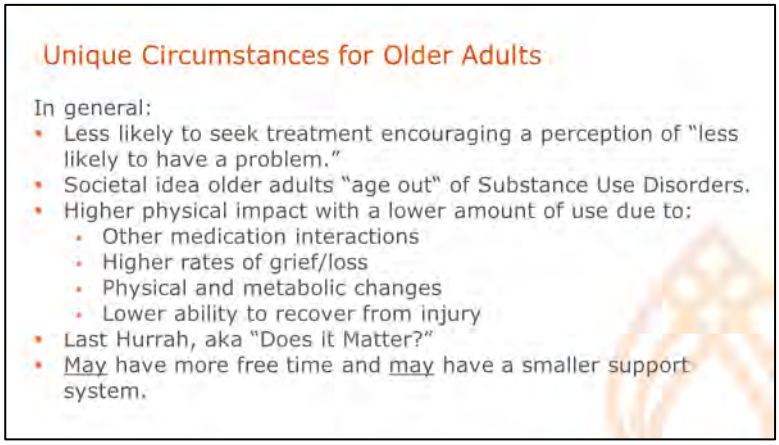
Share the following:

Many of those who work with older adults have gained tremendous respect for them because they are often people who have met challenges and adversity and have survived. Along the way they have received battle scars. Their individual temperament and traits interacted with those battle scars to create a unique individual with a personalized set of strengths and challenges.

Although APS works with older adults and adults with disabilities, this training will largely focus on older adults, as the research used in this content is based on that population. We recognize that APS may work with older adults who also have disabilities and some of the content today may or may not translate to those clients.

Throughout this workshop we need as a group, as APS professionals, to recognize that older adults who have a substance use disorder have a stumbling block out of which opportunity can be born. We mentioned SAMHSA's 4 dimensions: Home, Health, Purpose and Community and we will learn about SAMHSA's 10 guiding principles, which we will use throughout this presentation. Those principles provide guidance to individuals to help them create treasure from their stumbling blocks.

Slide #11: Unique Circumstances for Older Adults



Explain: We'll start by looking at the unique circumstances that older adults experience when using substances. These are circumstances which are typically not manifested, or seen, in younger populations.

Generally, for APS purposes, an older adult, is anyone between the ages 60-100+ or born between 1920's-early 1960's. APS professionals can benefit not only by considering the current population of older adults, but also by looking at how that population will be changing as the largest generation enters into older adulthood.

First, what are the overall unique issues of older adults who have substance use disorders?

Share the following:

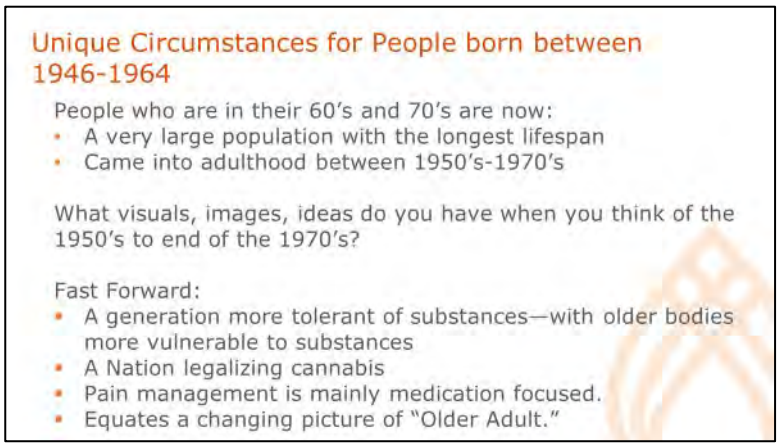
- Younger age groups are more likely to seek treatment which creates a societal perspective that older adults are less likely to have the problem.
  - For APS, this can mean that the person themselves, their support systems or even agencies that APS refers clients to may not consider substance use disorders and therefore the need to provide treatment.
- The perspective that older adults typically "age-out" of substance use has long existed.
- Older adults are more impacted by substance use for several reasons
  - Potential medication interactions
  - Higher rates of grief, loss and depression—potentially leading to higher choice of using maladaptive coping skills.
  - Physical and metabolic changes which allow drugs to impact them to a larger degree—meaning they have a lower tolerance.
    - Alcohol, which by far is the most used substance, can be used as an example of the way substances impact an older body.
    - As individuals age, muscle mass/lean body mass decreases. Metabolism slows. The human body has a lower water content, which impacts the blood brain barrier, a barrier that is

responsible for keeping harmful substances out of the brain. So, alcohol is *metabolized slower* and *more likely to impact brain function*.

- Lowered ability to recover from physical injuries. This increases the possibility of long-term use of potentially addictive pain medications. Development of a substance dependence more likely.
- More likely to have a smaller social support system, or to be isolated.
- More likely to have excess time in which to use.
- More likely to have any substance use issue seen as, “their last deserved hurrah” or unimportant because “at their age, does it matter?”
- If they do get treatment they are highly likely to have treatment developed from research done on younger adults.

(Chhatri, et al., 2017)

Slide #12: Unique Circumstances for People Born Between 1946-1964



Trainer note: this slide is animated.

Explain: Knowing there are differences between the current older adult population and the generation that is moving into older adulthood we can further define those differences.

- The generation, labeled as "Baby Boomers" are people born between 1946-1964 (now in their 60's-70's).
- They are beginning to change the profile of "older adults with substance use disorders" in several ways.
- Therefore, when working with this population, APS professionals will have to adapt to those differences and provide culturally responsive services.

Explain:

- Their life span, as of now, will be the longest.
- They are a very large population.
- They will have the biggest struggle for economic survival.

Ask: What comes to mind when you think of the span of time between the 1950's and the end of the 70's—the time they were growing up?

Possible answers: post World Wars, nuclear families, hippies, changing attitudes, drug and sex experimentation, civil rights.

Explain: They came to adulthood in the 60's and 70's; a time period of increased social tolerance for drug experimentation.

Fast forward 50 to 60 years to present day. This same population is now the rising older adult population.

- They have retained more tolerant acceptance of substances although their bodies are more vulnerable to the use of substances.
- Our nation overall has legalized cannabis.
- Pain management in our nation has become mostly medication focused, as opposed to other techniques of pain management.

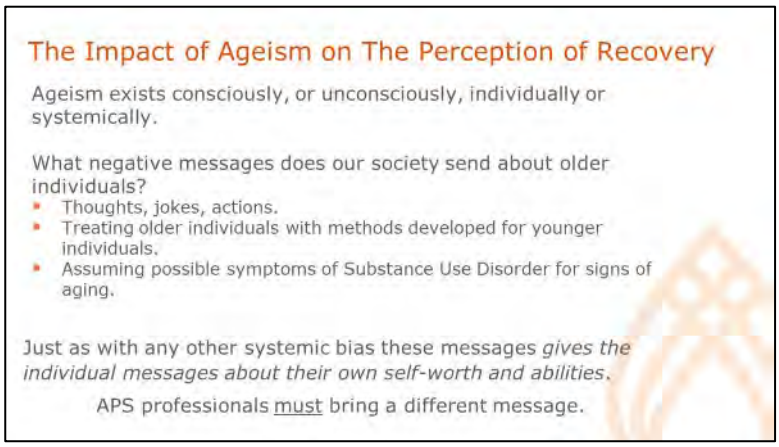
All of this is resulting in a changing population of older adults experiencing substance use disorders. One study showed that between 2002 and 2007 the use of illicit drugs doubled in older Americans. The same study showed that many of these adults had a lifelong use of illicit drugs. Note that "Older" in this study was 50 and up because long term substance disorder struggles age a person's body and mind. So, what we are seeing is both a larger group of aging Americans *with a history of substance use problems*, as well as a rise in Americans, who in older adulthood, *increase their use of substances* to the point where it becomes problematic.

(Chhatre, et al., 2017)

Ask: What problems does this present for you as an APS professional? How can APS professionals use this information to understand a person's values and assess a person holistically?

Possible answers: respecting an individual's norm while understanding this may create difficulty in seeing problematic use. Considering one's own beliefs on the use of substances, and how that intersects with a societal change in perspectives on substance use can create insight that maybe increase ability to assess holistically.

Slide #13: The Impact of Ageism on The Perception of Recovery



Trainer note: This slide is animated.

Share: that bias exists in virtually all parts of our lives and can be conscious or unconscious. People can have ageist beliefs both individually and as a systemic bias, where a system adopts a biased idea and operates on it. Ageism is a bias that is unique in that everyone will at some point in their lives will experience it.

Ask: What negative messages does our American society send about older adults?

Possible answers: TV stereotypes, articles about "things boomers did that no one does anymore." The polite, "Oh no, let me do that for you" (because you are old) messages. Jokes, "the big 40, it's all downhill from here," or "can't teach an old dog new tricks."

Explain:

Ageism also exists with substance use issues:

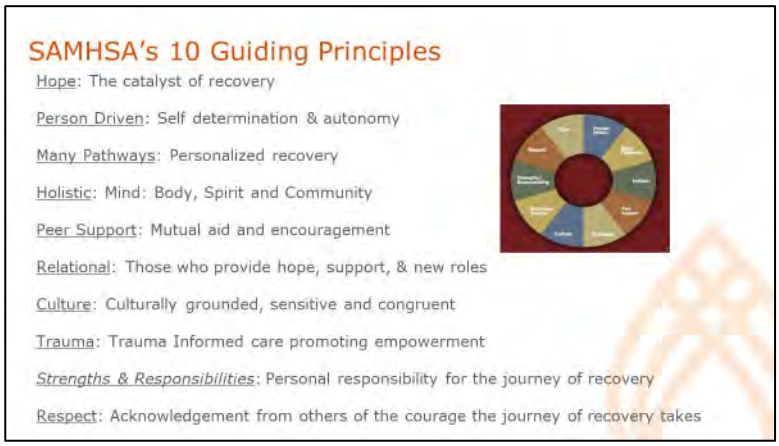
- The, "oh let them, it's the end of their life" attitude.
- "They've been doing it this long, they won't change."
- "Older people age out of substance use."

All of these are manifestations of systemic bias and, just as with any other systemic bias *gives the individual messages about their own self-worth and abilities*.

There is also personal stigma attached to substance use for any age group, where the person themselves has a biased perception of why they have this disorder. Older generations were often taught that substance use was a moral failure and a weakness. When paired with ageist beliefs that society sends older adults can have a painful sense of worthlessness and shame.

One of the most important interventions APS professionals can bring to an older individual is a different message. That message can be provided with psychoeducation about substance use disorders. It can be provided by validating their ability to make decisions and build a life that is based on their wants and needs without listening to negative messages from others, or themselves. We are going to look at the SAMHSA 10 to help us consider how to do that.

Slide #14: SAMHSA's 10 Guiding Principles



Explain: We are going to take our first look at SAMHSA's 10 principles of recovery, found on **Handout #1- SAMHSA's Guiding Principles of Recovery.** This should become a picture frame through which you view recovery. We will look at them and then we will do an activity.

- For those who are willing to approach the tremendous challenge of recovery, our goal, no matter how small our role in their life, should be to help them gain a sense of self-efficacy and understand they have the self determination to use their life in a way that leaves them with a sense of integrity.
- SAMHSA's 10 guiding principles for recovery can be a catalyst for this process. These are something an APS professional can keep in mind each time they interact with someone who may have a substance use disorder.

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

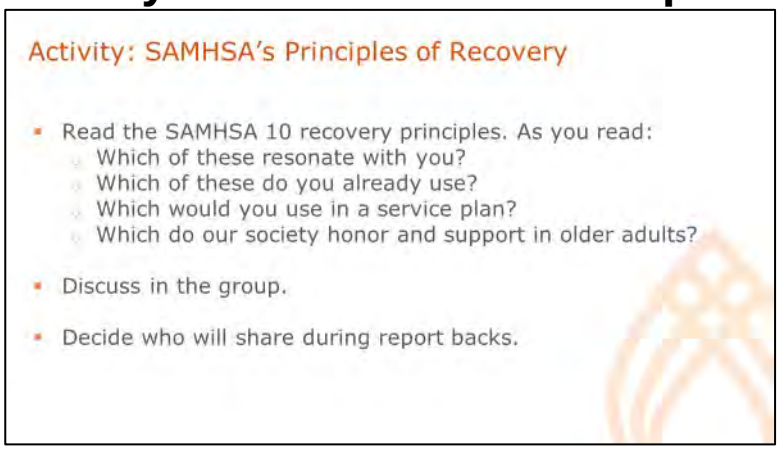
Individuals, families, and communities have strengths and resources that serve as a foundation for recovery. In addition, individuals have a personal responsibility for their own self-care and journeys of recovery. Individuals should be supported in speaking for themselves. Families and significant others 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

Slide #15: Activity#2: SAMHSA's Principles of Recovery



Activity #2- Clarifying Recovery (25 minutes with report backs)

Breakout Groups

Share the following instructions and **check** for understanding:

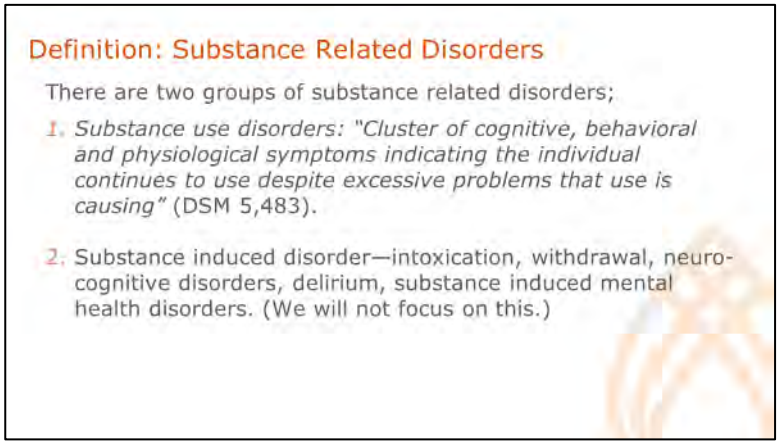
In breakout groups:

1. Take five minutes to read over the SAMHSA 10 Recovery Principles in **Handout #1**.
    a. As you read, think about:
        i. Which of these resonate with you?
        ii. Which of these do you already use?
        iii. Which would you use in a service plan?
        iv. Which do our society honor in older adults?
2. Take seven minutes to discuss the prompts on the slide in the group.
3. Decide who will share out in the larger group.

Launch breakout groups for 12-15 minutes.

Welcome groups back and for 10 minutes, **ask** for each person to summarize their group discussion. **Highlight** any themes or differences between the groups.

Slide #16: Definition of Substance Related Disorders



Explain: Having looked at unique factors of older adults and substance use disorders, and having considered what aids them in recovery we will move onto defining what a substance use disorder in an older adult is.

There are 10 classes of drugs, all of which "produce an intense activation of the reward system" (DSM 5, 481).

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 are going to focus on the first one; Substance Use Disorder (SUD).

- As we said it is a cluster of cognitive, behavioral and physiological symptoms *with the continued use of the substance despite those symptoms*.
- In other words, it is *the way they are thinking*, *how they are acting* and *what is happening to them* that identifies if there is a disorder. Impairment is seen in thought, action, and medical or mental health.

Slide #17: Substance Use Disorder

Trainer note: this slide is animated to reinforce the definition.

Let's break down this definition in practical terms:

First, they have impaired control over their use, taking the substance:

- In larger amounts, or over a longer period than was intended, despite,
- Persistent efforts to cut down or control use.
- They spend a great deal of time obtaining, using or recovering from the effects.
- The individual experiences cravings or a strong desire to use a substance—often experiencing times when they can think of nothing else.

This leads to social impairments and consequences:

- A failure to fulfill major role obligations at work, school or home
- Continuing that use despite persistent social or interpersonal problems including neglecting their ADLs or IADLs.
- Social, occupational or recreational activities are given up or reduced because of use.

And, substance use continues despite the risks—*and an awareness of the risks* such as:

- Recurrent use in situations where it is physically hazardous or,
- Continued use despite the knowledge there is physical or psychological harm the substance is likely to have caused or exacerbated.

There are Pharmacological Indicators or Symptoms:

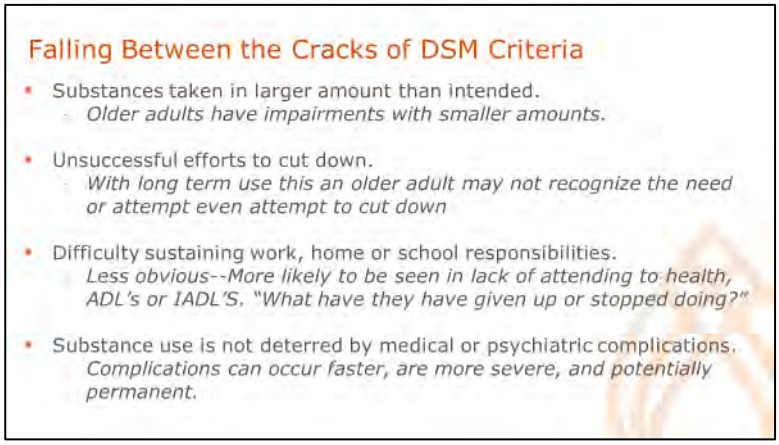
- Tolerance as defined by a need for markedly increased amounts to achieve same effect, or a diminished effect with use of the same amount.
- Withdrawal or using substance to avoid withdrawal symptoms.

All of this boils down to how current substance use is affecting a human life and what its purpose in that life is?

- Does a person have a bad day and take a drink, a pill or a hit, to relieve some stress periodically—and then they don't for another week or month or more?
    - Or, is using a substance their main coping strategy—a daily escape?
- Do they use to avoid? To block problems instead of managing and solving problems?
- Does the substance replace other coping skills? Including responsibilities to others?

Everyone has different ways of coping with life. Strategies can be healthy or unhealthy. Substance use is a maladaptive coping skill that can trap an individual into continually repeated cycles of overuse.

Slide #18: Falling Between the Cracks



Trainer note: this slide is animated.

Share that the DSM-5 has a list of criteria. However, older adults can have substance use disorders and not meet the diagnostic criteria because the criteria are not created with them in mind. This information is not given with any expectation an APS professional will diagnose. It is to help gain understanding of what factors into a diagnosis and why these factors could result in difficulty when diagnosing an older adult.

Share the following criteria and challenges applying that SUD criteria to older adults:

- Substances taken in larger amounts than intended.
  - Older adults have impairments with smaller amounts.
  - Can be taking medications, or have medical or neurological disorders that makes **any** substance use harmful.
- Unsuccessful efforts to cut down.
  - With long term use an older adult may not see that as a problem despite increased consequences.
- Difficulty sustaining work, home or school responsibilities.
  - Harder to see if these responsibilities are reduced. More likely to be seen in lack of attending to health, activities of daily living, or instrumental activities of daily living. Consider or ask about changes that have occurred in their lives, what they have given up or stopped doing.
- Substance use is not deterred by medical or psychiatric complications.
  - Complications are more severe and potentially permanent and can happen much more quickly.

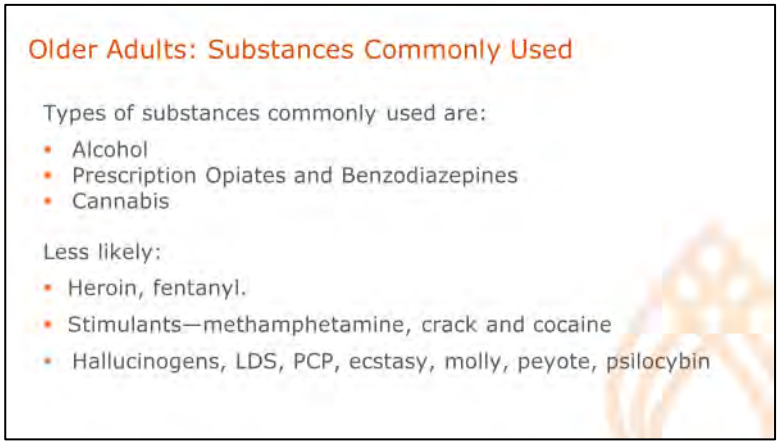
Explain: If they are not in many social situations; work, school, community and family groups, they may not be in a situation where these criteria are observable so they can quietly slide into negative consequences.

What diagnostic criteria remains the same for older adults?

- They still have cravings.
- Excessive time working to obtain and use substances
- Use of substances continues even with the recognition of negative consequences in interpersonal situations, or decrease in socializing.

(Lehmann & Fingerhood, 2018)

Slide #19: Older Adults: Substances Commonly Used



Share: An important role for an APS professional is ensuring that the client understands the risks and benefits of their decisions, and when necessary, helping them to mitigate the risks. In this section, we'll be covering the most common substances used in the older adult population and the risks associated with them.

Keep in mind that one of challenges for many people, including older adults is remembering everything they take, including over the counter medication's (OTC) and supplements. They may also be unaware of how some of the OTC's and supplements can have contraindications when taken with prescription medications. Additionally, there may be a problem with "borrowing" from others. It can be difficult to be fully understand their total intake, thus making it confusing for them, their support system and those offering services.

Types of substances commonly used are:

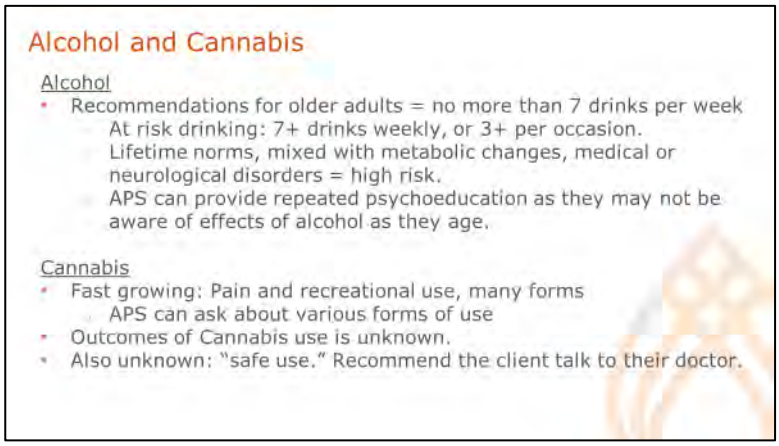
- Alcohol
- Prescription Opiates and Benzodiazepines
- Cannabis

Less likely:

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

Share that we'll look at each of these more in depth in the following slides, and if participants would like more information on how these substances might show up in the lives of people they work there, they can access the Resource Guide both on the APSWI website and in their participant manual appendix

Slide #20: Alcohol and Cannabis



Trainer note: this slide is animated to first discuss alcohol and then move to cannabis.

Explain the following information on Alcohol**:**

The Guidelines from American Geriatrics and the National Institute for Alcohol Abuse and Alcoholism have recommendations for older adults:

- No more than 7 standard drinks per week.
  - (12 oz beer, 5 oz wine, 1.5 oz of 80 proof)
- At risk drinking: More than 7 drinks per week, or more than 3 drinks per occasion.
- Binge drinking: 5 or more standard drinks in one drinking episode.

(Kuerbis, et al., 2014)

Explain: Because in older adulthood lower amounts of alcohol can create higher vulnerability to negative impacts, *even if an older adult sustains the amount of alcohol, they have been able to tolerate for years they can still be at risk*—but this may occur without awareness, or with resistance to seeing the problem. This means for a lifetime drinker, especially a lifetime heavy drinker, their norm can be damaging.

This is not only because of the changes in metabolism, but also due to health issues that can develop; neurological disorders, potential medication interactions and lower risk tolerance to physical injury. If an APS professional sees, or suspects, that long term use is impacting a client more than they are aware of because of those aging processes, psychoeducation can be provided to help them understand. Expect that it will need to be repeated.

(Vestal, et al., 1977)

(Lehman and Fingerhood, 2018)

(Le Roux, et al., 2016)

Share the following information on Cannabis:

Older adults are the fastest growing population for the use of cannabis. Research on older adults and cannabis use is minimal, so there is not a lot of information on what risks it may carry. What we know is complicated by the fact that Cannabis use has many dimensions. From the reasons that people take it, medical or recreational, to methods of ingestion, to the different strains to the active components it is a diverse substance.

There are multiple ways to use cannabis; smoking, vaporizing, edibles, home baking, dabbing, suppositories, patches, sprays & topicals (application). This matters and is important for APS to assess when discussing use with clients. Cannabis impairs a person's ability to function both mentally and physically—but means of ingestion can change how that happens.

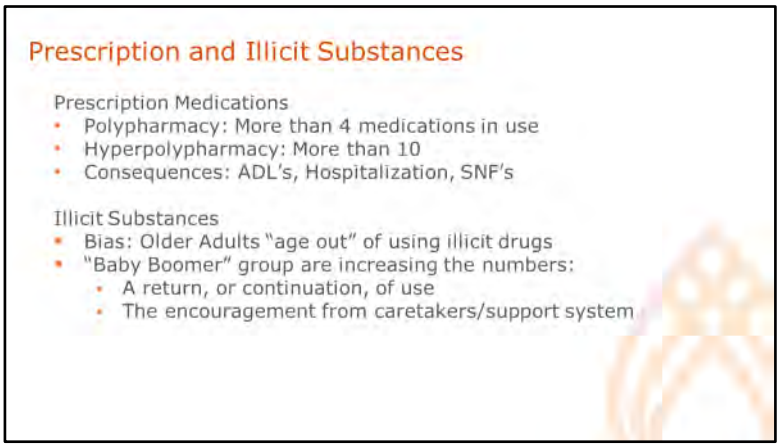
- Example: the traditional route of smoking cannabis means the person is impacted within minutes, however if edibles, which are growing in popularity, are used a person will not feel the full effect for 1-3 hours. The variability alone can increase risks for older adults.

(Stella, 2023)

Explain: Individuals with neurological disorders can face a stronger impact and more harm. The overall picture of cannabis use is blurry. It is a relatively new category of substance use because the legalization makes it available in a way that it previously was not. Exactly how cannabis affects the brain, including the older adult brain will take time to research.

We do not know what "safe" is. So, the only suggestion we can make with an older adult using cannabis is to encourage them to discuss it with their doctor and validate that it can be difficult to share with a doctor given it was illegal for so long or still is in some areas.

Slide #21: Prescription and Illicit Substances



Trainer note: this slide is animated to first discuss prescriptions and then move to illicit substances.

Share the following information on use/misuse of prescribed substances:

The common prescription medications are the pain relievers (often opiates) and benzodiazepines, such as Xanax, and medications ending with "pam" or "lam," such as Clonazepam, Diazepam, Alprazolam etc.

Polypharmacy is defined as the use of more than 4 medications at one time, with the use of ten or more being termed "hyper polypharmacy."

- Polypharmacy is quite common with estimates of between 37% and 58% in older adults who live independently engaged in it. It can be intentional, when an adult overuses or takes a substance for a reason other than the medication is meant, or unintentional if an individual is prescribed multiple drugs and has difficulty with correct dosages or tracking their use.
- Polypharmacy has a laundry list of consequences from increased hospital admissions and placement in a skilled nursing facility to mobility and cognitive issues to incontinence, difficulties performing ADL's, and decreased quality of life.

(Morgan et al., 2011)

(Lehmann & Fingerwood, 2018).

(Scott et al., 2019)

Share the following information on use of illicit drugs**:**

Previously the use of illicit substances was viewed as an issue that individuals "aged out of." This was a bias that ignored the reality of older adult substance use. It is now understood the number of illicit substance users has been increasing.

- Data shows an increase in drug use in the over age 35 population, which has been linked to the “baby boomer” group.

Explain:

- Individuals who use these types of substances and are becoming older adults are split into two groups: early and late onset.

Ask: Why would a person begin using in later life?

Possible answers may include:

- *Late onset use may be encouraged by a caregiver, friend or abuser who introduced substance use to an older adult, possibly to make their own lives easier, or to control the adult.*
- *May be a continuance of lifetime patterns—with larger consequences.*
- *Possibly a return to old patterns after a period of recovery due to pain and mental health issues.*
- *Some older adults manage chronic pain with prescription medications only to have those medications decreased due to tracking and management strategies. At which point they may turn to illicit means.*

While there are some pharmacological aids for managing substance use disorders those aids do not impact all substance use. Motivational interviewing and therapy have been shown to be effective in recovery, and will be discussed later on.

(Ghantous, et al., 2021)

Slide #22: Risk Factors in Older Adults

Share that there are many puzzle pieces present when trying to unravel the mystery of why substance use disorders happen. Why do some individuals struggle with the cravings that come back over and over to haunt them?

While others never struggle, and often don't understand why the individuals who are grasped tightly by the disorder can't "just stop."

APS professionals can look for risk factors when assessing a client. Some of those puzzle pieces are risk factors like:

- Certain demographics
- Genetic vulnerability,
- Environmental reinforcements,
- Drug availability,
- Lived trauma--which predisposes both towards mood disorders and trauma triggers, both of which can encourage substance use.

It's important to keep in mind that these are potential risk factors, and <u>don't automatically equate to substance use disorders</u>.

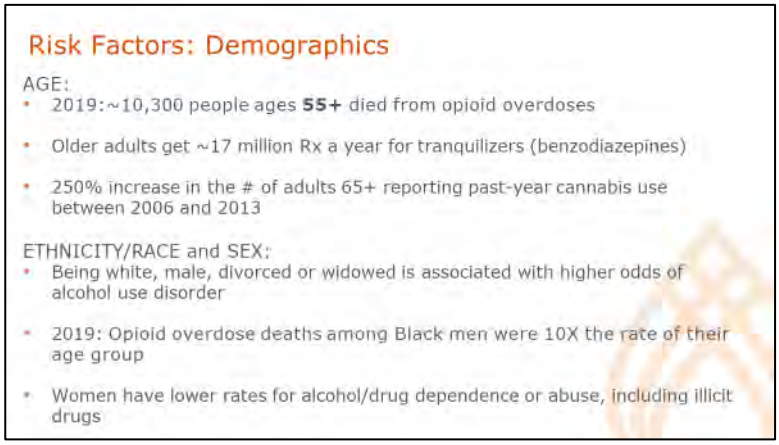
A large part of APS work, is to:

- First understand risk factors in general, then
- Identify if they exist with the people they work with, and
- Move to assessing if the risk factors are indicators that there are safety or well-being concerns and
- Work to mitigate them.

Understanding these puzzle pieces as potential red flags to a possible substance use disorder, allows APS professionals to be a more impactful part of the recovery process.

We'll be looking at them more in depth in the following slides. Let's start by looking at the demographics. (Levis et al., 2021) (Kim et al., 2019)

Slide #23: Risk Factors: Demographics



Review: the below demographic information and ask about any themes they participants see.

- In 2019, nearly 10,300 people ages 55 and older died from opioid overdoses, compared to just over 500 in 1999.
- Older adults get almost 17 million prescriptions a year for tranquilizers (benzodiazepines).
- Being white, male, divorced or widowed is associated with higher odds of alcohol use disorder.
- Women have lower rates for alcohol/drug dependence or abuse, including illicit drugs.
- In 2019, deaths due to opioid overdose among Black men were 10 times the rate of their age group.
- Research data shows a 250% increase in the number of adults aged 65+ reporting past-year cannabis use between 2006 and 2013.

(Law, 2022)

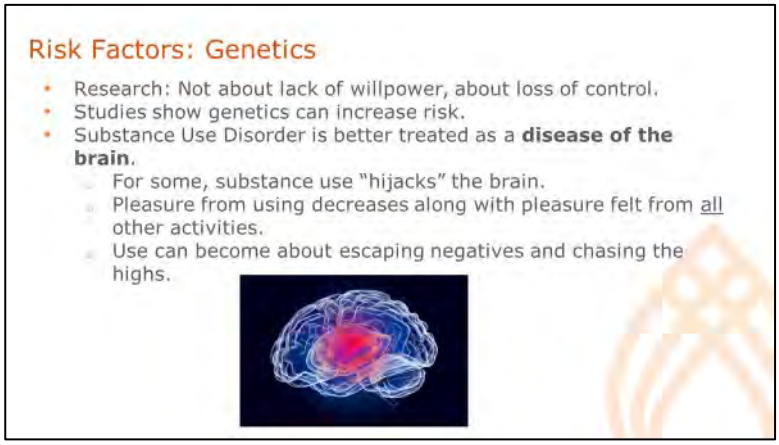
(Scott, et al., 2019)

(Williamson, et al., 2018)

(Chhatre, et al., 2017)

(Stotts, 2022)

Slide #24: Risk Factors: Genetics



Explain: Beginning attempts to understand substance use disorders in the 1930's *made it clear that addiction was not about lack of willpower, rather it was a loss of control*. There is evidence that addiction is a disease of the brain which creates neurological disruptions in behavioral control and decision making. There was also a realization that patterns of substance use disorders often existed in biological families. This means families can be studied for better understanding of these disorders.

Share the following information:

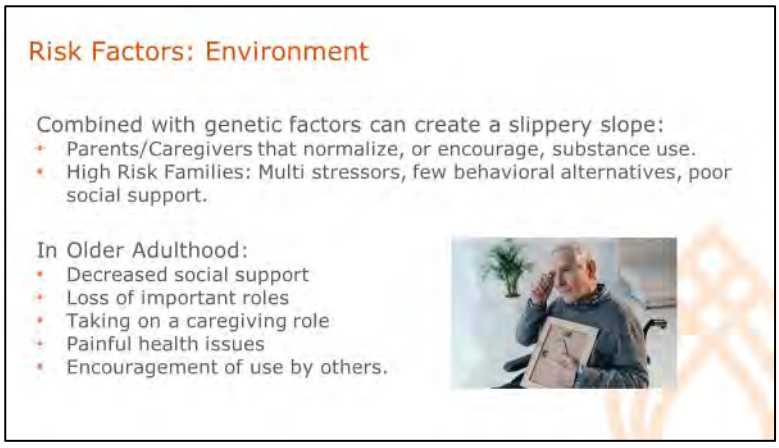
- There have been multiple studies on:
  - Chromosomes & Genetics—understanding the genes that are linked to substance use and how they are passed down.
  - Families with generational patterns of substance use and mental health disorders.
  - Biological families separated by adoption.
- Studies on children separated from their biological family at birth shows even when growing up in substance free home, they have a similar risk of developing a substance use disorder as do the siblings who grew up in homes where parents experienced substance use disorders.
- Not everyone who uses substances becomes addicted. An estimated 10% of people trying addictive substances have their brain hijacked. There also tends to be a "drug of choice," a substance the person cannot control, while the same person can successfully abstain from other substances. (Ex. What foods do you keep out of the house?)
- It is not unusual for individuals to discuss how that first high was the best high, or to spend years chasing another one that is that good.
- One of the brutal components of this disease is that as it progresses the pleasure from using the substance decreases, but also the pleasure of non-substance use activities decrease—because the brain's reward

centers are increasingly compromised. This can mean substance use can become about:

- Avoiding what is perceived as a negative reality.
- Managing an increased sensitivity to stress.
- Escaping the painful dopamine dump.

Individuals are trapped in a cycle of using over and over and over to escape the negatives and chase the high. (Ex. Meth and Depression after cessation of use.)

Slide #25: Risk Factors: Environment



Share the following information about environment:

- Environmental factors that influence the use of substances are:
  - Parents/Caregivers that normalize substance use and have substances easily available and may encourage—or insist on use.
  - High risk environments (multi-stressed families) are families who have many challenging situations; racism, trauma, poverty, paired with few behavioral alternatives and poor social support. In these circumstances it can be difficult for people to know how to regulate emotions or problem solve because they were never taught. If they experience a constant waterfall of problems the inability to regulate emotions can lead to a focus on avoidance and escape.
  - Peer pressure can contribute to the initial step of trying substances.
- For those with a genetic risk factor this can be a slippery slope into immediate or gradual dependence on a substance. At the same time, it is not unusual for a family with a generational history of substance use issues to have individuals who never have any struggle with substance use.
- In later life environmental factors that can activate misuse of substances are life events that older adults frequently face:
  - Loss of loved ones.
  - Taking on a caregiving role.
  - Isolation.
  - Health issues (with accompanying pain).
  - Encouragement of use by others (to gain control.)
  - Retirement, which no matter how an individual looks forward to, still means they lose a role they have fulfilled and very possibly found satisfaction in.

(Kim et al., 2021)

(Wang, et al., 2012)

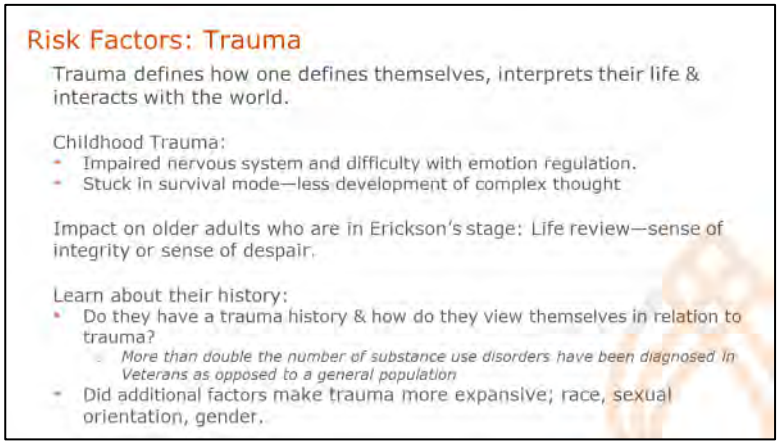
(NIDA, 2019)

(Volkow, et al., 2016)

Ask: How is having this foundational knowledge of environmental and genetic risk factors something that will help an APS professional?

Possible answers: helpful to assessing the likelihood of problem, helpful to consider influences on the client, helpful if other family members have recovery stories that might hold clues to what might be most supportive to the client.

Slide #26: Risk Factors: Trauma



Trainer note: this slide is animated.

Share that trauma is a risk factor to many situations including increased risk of substance use, misuse and disorders.

There are many dimensions of trauma that we'll outline here.

The Threefold Impact

Trauma impacts:

- How an individual defines themselves--their identity.
- How an individual views their life--how they interpret meaning in life events.
- How an individual views their interactions with others in the world.

Studies of trauma and trauma reactions across different age cohorts shows the impact of early childhood adverse events does not "fade away" and humans do not "age out" of trauma. From initial impact to death the ramification of trauma remains with an individual.

Childhood Trauma

Explain: When children are involved in, or witness to, events such as abuse, neglect, community violence, or parents/caregivers who have substance use or mental health issues, these children can grow up without a consistent sense of safety. This means they grow up with an impaired nervous system that can be easily triggered by small things their brain misinterprets.

- Ex: All slamming doors mean danger. A car honking or backfiring means danger. A loud voice, the sense someone is behind them, a word, a smell, many, many things immediately activate their nervous system to fight against danger.

The second impact of trauma in childhood is they learn to function in survival mode by using the lower "flight, fight or freeze" brain processes. This leads to less functioning and development of the higher and more complex brain processes.

The third impact of trauma is that growing up without a safe space, or a safe person makes it difficult to learn healthy ways of regulating negative emotions. This is why individuals who have experienced trauma often turn to maladaptive coping skills, such as substance use. Depression in older adulthood has a strong correlation with early childhood trauma.

Complex Trauma

There is also something called, "complex trauma." It is defined as:

"Prolonged or severe exposure to interpersonal trauma—particularly when onset begins in early life within the child's primary caregiving relationships or living situations.

Complex Trauma Resources – Resources for Survivors and their Helpers

Impact of Trauma on Older Adults

Erik Erikson, who developed the influential theory of the psychosocial stages that each person goes through in their life stated the older adult stage was a life review. The potential outcome of this stage is either a sense of integrity or feeling a sense of despair about one's life. Trauma can interfere with this stage and create a challenge because the person's history is likely to be a point of reference in this life review. When a life is shaped by trauma it influences how an individual assigns meaning to life events and choices and the person can have difficulty having a positive life review.

(Colbert & Krause 2009)

Knowing the History

- Some populations are more vulnerable to substance use disorders due to a likelihood of being more heavily exposed to severe and/or sustained trauma. Veterans and the LGTBQ+ community are some of the more vulnerable populations.
    - Multiple studies have shown more than double the number of substance use disorders have been diagnosed in Veterans as opposed to a general population.

Asking about traumatic events in their lifetime can be helpful to the process of developing a treatment plan. Additionally, ask how their ethnicity, their sexual orientation, or their gender may have added to their experiences of trauma. These questions may provide a space for APS professionals to provide psychoeducation. Be aware of how they see themselves. As a trauma survivor, or

a trauma victim? From that perspective is how they have interacted with their world. Helping them to reshape that narrative can reshape how they relate to their world and how they see their future.

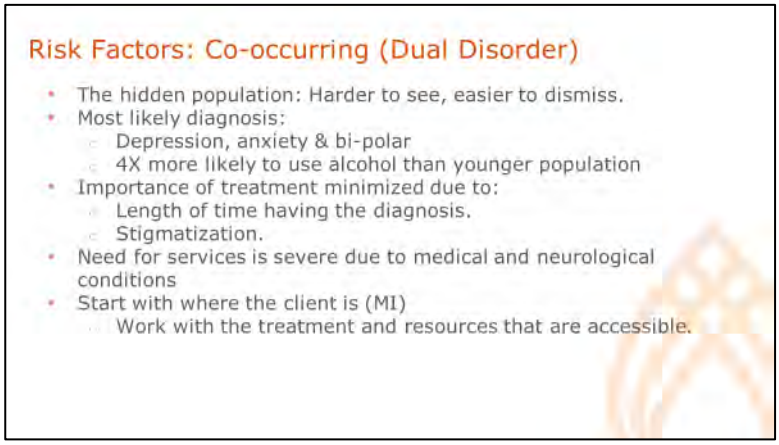
(Bernsten & Rubin, 2006)

(Roux et al., 2016)

(Levis et al., 2021)

(Kim et al., 2019)

Slide #27: Risk Factor Co-Occurring/Dual Disorder



Explain: Co-occurring disorders, also known as Dual Diagnosis, is a combination of a substance use disorder and a mental health diagnosis.

- There is not a large body of research on older adults with dual diagnosis. This may be because they have been called the "hidden population," just as the rise in older adult substance use disorders has been termed, "the hidden epidemic."
- The reason remains the same; substance use is harder to see and diagnose and it is dismissed more easily in the older adult population.

What research we do have, shows:

- That mental health disorders can lead to substance use as a means of dealing with the symptoms of the mental health disorder.
- Depression is one of the most likely mental health disorders in a co-occurring diagnosis, and older adults are up to 4x more likely to use alcohol to cope with depression then a younger population.
    - Anxiety and bipolar disorders are also common mental health issues in older adults who have dual disorders.
- The following are reasons why some older adults are likely to minimize the importance of treatment for mental health because:
    - They have lived with mental health issues so long.
    - They find medical issues more concerning.
    - They stigmatize treatment for both mental health and substance use disorders.

When working with someone who has a dual diagnosis, realize that the need for services is more imperative because neurological issues are more prevalent in older adults with dual disorders.

- Also consider the potential barriers such as:
    - Transportation.

- Possible cultural issues.
- Lack of information (understanding) for the older adult—which an APS professional can address.
- Indecision among professionals who are questioning what the primary problem is. Should the person see a mental health practitioner, or a substance use counselor? Will they get substance use treatment and find there never was a mental health disorder? (It is unlikely, however this how people think.) Or do they have a neurological disorder—then that is a completely different provider.
    - As a nation, we have yet to accept that integrated treatment is best.
- In an older population the problems may have begun so long ago that the reality is often, that answer is long lost. Also, the correct question is: What needs to be addressed now? An APS professional may start by determining what treatment can be provided, what resources can be given?

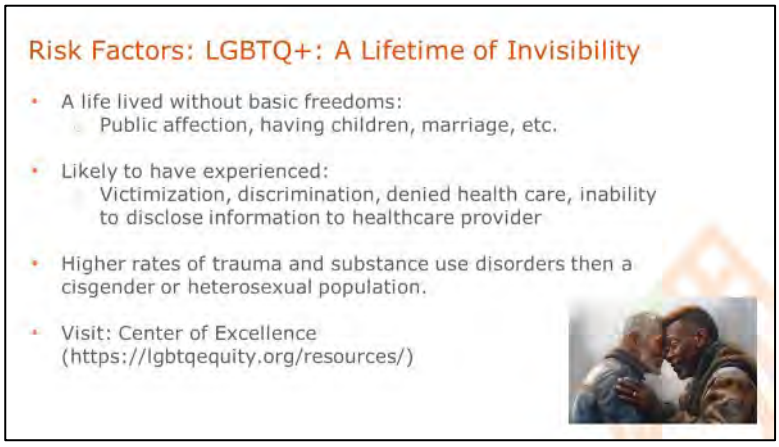
(Searby et al., 2015)

(Crome, & Rao, 2011)

(Morse et al, 2015)

(Proctor et al., 2015)

Slide #28: Risk Factor: LGBTQ+: A Lifetime of Invisibility



Explain: While the demographics show multiple groups of people historically targeted for marginalization have additional risk factors, we are going to focus for a moment on the older adult LGBTQ+ population because they were likely to have lived all, or part of their life unable to engage in some of the most basic freedoms and human behavior that many heterosexual, cisgender folks never think about: i.e. having children, physical affection in public, marriage, given family support, societal acceptance.

Instead, they are much more likely to have experienced:

- Victimization (2/3rds), Multiple incidents of discrimination.
  - Including job discrimination, which shows in the number of older LGBTQ+ adults living in poverty.
- Denied healthcare (13%).
  - Or felt unable to disclose important information to their physician (20%).
- Entering older adulthood without a partner or a family support system.

Research is needed on substance use in the older LGTBQ+ population. However, what exists shows there are high rates of trauma and substance use disorders. In a recent study, LGTBQ+ adults age 50 and up reported more cannabis use, alcohol use, prescription opioid and tranquilizer misuse than did the heterosexual/cisgender population.

Share the following resources from SAMHSA, which participants can access after training:

- Center of Excellence (https://lgbtqequity.org/resources/)

- LGTBQ+ trauma informed care that can be used when working with this population (https://lgbtqequity.org/wp-content/uploads/2021/06/Trauma-InformedCare-Final.pdf)
- Animated Short on Providing Equitable and Affirming Care to LGBTQ+ Older Adults - YouTube (https://www.youtube.com/watch?v=Tqryt-j94cY)

As we begin the section on recovery, consider how the principles of recovery can help all populations, including the most vulnerable populations.

(Han & Palamar, 2020)

(Fredriksen-Goldsen, et al., 2011)

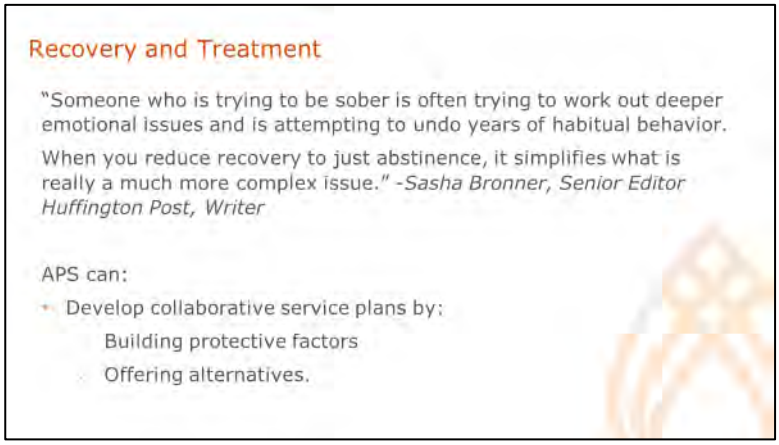
Recovery and Treatment

Time Allotted: 45 minutes

Associated Objective(s): Summarize SAMSHA's 10 principles of recovery as they apply to working with those served by APS

Method: Case scenario and breakout groups, Lecture and Q&A.

Slide #29: Recovery and Treatment



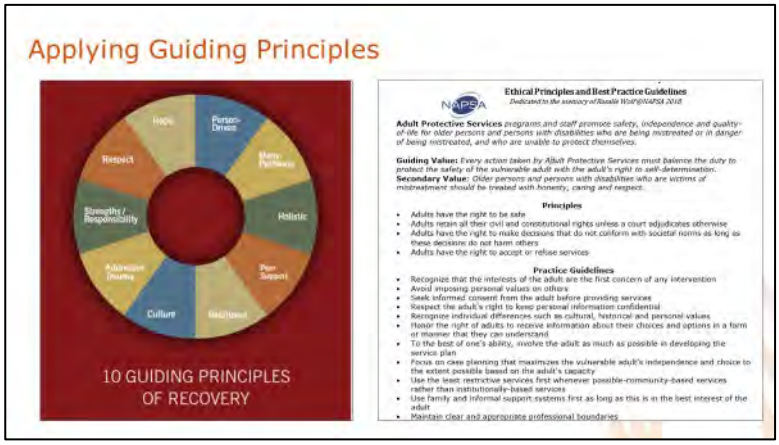
Ask a volunteer to read the quote on the slide.

"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*

Explain: APS professionals seek to *maximize independence, resolve crisis, and support individuals*. Collaborative service plans seek to build upon individual strengths and resolve needs, *with* the co-partnership of the client. *This is where the APS professional can build protective factors*. Sometimes in order to help we do not directly confront the issue, rather we provide **competition**—alternatives which can make the substance use less central to a human life.

As stated, older adults experience many life changes: families growing up, the end of jobs that had been central in their life, often a shrinking support system. The number of stressors may increase as the aging process can provide limitations, or personal health issues, either for themselves, or of a loved one. Trauma and mental health issues that an individual felt they had learned to manage, or may have avoided for years can resurface during their life review. An older adult may be experiencing a sense that life is not as relevant as it had been.

Slide #30: Applying Guiding Principles



Explain: Substance use is a method of avoidance. Few individuals avoid what is pleasurable, satisfying, or life fulfilling. To help an older adult approach the tremendous challenge of recovery, our goal, no matter how small our role in their life, should be to help them build their ability to continue their life in a way that provides a sense of purpose, a feeling of integrity about how they are using their time. They should also be encouraged in the idea they can use their strengths to create a life they want to be present for.

- This is where we will further consider how to use SAMHSA's 10 guiding principles as a catalyst for recovery.
- We are also going to pair NAPSA's principles with SAMHSA 10 guiding principles and use both to drive collaborative, respectful and person-driven interactions, and service plans.

Give participants a few minutes to read through the NAPSA principles and look at the SAMHSA principles once more in preparation for the next activity.

Handout #2: NAPSA's Ethical Principles

Ethical Principles and Best Practice Guidelines

Dedicated to the memory of Rosalie Wolf ©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
- 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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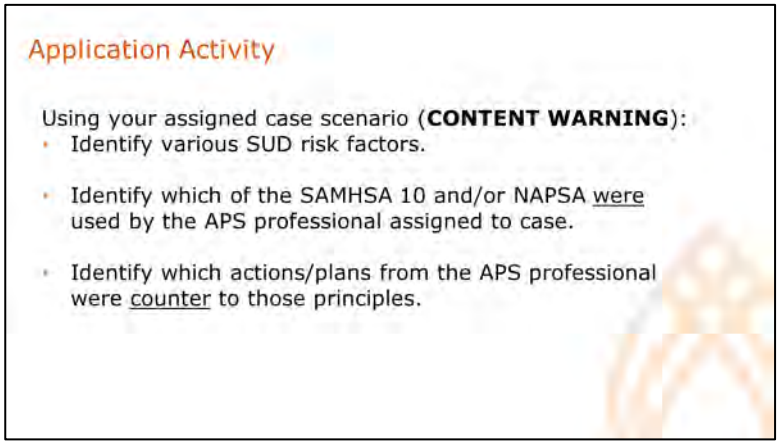
Slide 31: Application Activity



Trainer note: This activity allows participants to identify which of the risk factors for SUD covered in earlier content might be present in each scenario as well as identify which SAMHSA and/or NAPSA Principles were and were not used.

Activity #3: Applying Principles to Scenarios (30 minutes total with report out)

Breakout groups

Instructions:

- **Divide** participants into groups of 3-4 and **assign** each group a case scenario (case scenarios may be used more than once).
- **Content Warning: Explain** that each scenario may have factors that activate feelings or memories from participant's own experiences, personally or professionally and that taking a break is encouraged if needed.
- **Share** that participants have five (5) tasks to complete in their 15-20 minutes
  - Read their scenario.
  - Decide on a spokesperson to share group findings during report outs.
  - Identify which SUD risk factors possibly exist.
  - Using **Handouts #1, #2 and #3** identify
    - SAMHSA's principles in use.
    - NAPSA's principles in use.
  - Identify what was done that is counter to the principles.
- **Allow** participants 15-20 mins to complete the activity.
- **Conduct** a 10 min report out, **asking** spokesperson to summarize their group's discussion.

Trainer note: *This should lead to discussion. Ideas and thoughts will vary. There are likely to be different perspective and multiple answers, all of which can be considered and discussed*.

Possible answers:

Scenario #1 (Shonda):

- *Risk Factors:*
  - *Environmental (grief/loss of partner, possible painful health issues due to falls),*
  - *Demographics (Black, LGBTQ+),*
  - *Trauma (car accident)*
- *Principles used:*
  - *SAMHSA 10-Culturally- Based (discussing art work),*
  - *NAPSA-Secondary Value- Treated with honesty, caring, respect (informed Shonda of the allegations).*
- *Actions counter to Principles:*
  - SAMHSA 10
    - Address Trauma:
      - No *sign of asking her about being LGBTQ+, possible trauma she may have incurred—and learned to be silent about. Did not discuss the car accident and traumatic loss of wife.*
    - Many Pathways:
      - *No sign of consideration of what kind of support she may be able to receive from being LGBTQ2+.*
    - Relational*:*
      - *Was the neighbor a possible means of support, not someone "tattling" on her? Q: How does it help if the cause of the report is left undiscussed and the possible means of support not explored?*
  - *NAPSA:*
    - Do no harm. Inadequate or inappropriate intervention may be worse than no intervention. *Q: Can the APS professional do a thorough intervention when he did not ask about originating reason for report?*
    - Avoid imposing personal values on others *Q: Was it a personal value to decide not to pursue questions on drinking because the client was sad?"*

Scenario #2 (Charles):

- *Risk Factors:*
  - *Demographics (White, Male),*
  - *Genetics/Environment (parents with SUD, in recovery)*

  - *Environmental (Painful medical conditions),*
  - *Trauma*
- *Principles used:*
  - *SAMHSA 10:*
    - *Hope*
- *Actions counter to Principles:*
  - *NAPSA:*
    - Recognize the interests of the person are the first point of any intervention. *Q: By making decisions about client's needs before meeting him was this upheld?*
    - Maintain clear and appropriate boundaries. *Q: Does our desire to help others sometimes get in the way of helping others? Did APS professional avoid placing personal values on others.*
  - *SAMSHA 10:*
    - Mutual Aid and Encouragement*: Q: Professionals help form the Mutual Aid and Encouragement. With the pre-determination of the client's needs will this happen?*
    - Trauma Informed Care*: Is there a grasp of the trauma the client endured? Will the APS professional empower him through understanding his trauma, or will he skip the Trauma informed care because the client has managed it up to this point?*

Scenario #3 (Rainbow):

- *Risk Factors: Co-Occurring (anxiety disorder and SUD), Trauma*
- *Principles used:*
  - *NAPSA: Right to self-determination*
  - *SAMSHA 10: Many pathways.*
- *Actions counter to Principles:*
  - *No clear actions counter to principles.*
    - *Did the APS professional catch herself as she began to think counter to principles? Did she center herself in the values of her profession? Had she continued thinking as she began what values might her actions have been counter to?*

Scenario #4 (Gonzalo):

- *Risk Factors: Demographics (Hispanic), Trauma*
- *Principles used:*
  - *SAMSHA 10: Many Pathways*
  - *NAPSA: Right to make decisions that do not conform to societal norms.*
- *Actions counter to Principles:*

- *NAPSA*
  - To best of their ability involve the adult in developing the service plan." *Q: Is the APS professional thinking in a way that involves the client?*
  - Adults have the right to be safe*." Q: Are potential risks being ignored?*
- *SAMHSA 10*
  - Person Driven *Q: Is the client's self-determination and autonomy being prioritized?*
  - Holistic: *Will the Mind, Body, Spirit, Community, need for Self Care, transportation, clinical treatment, healthcare, etc. be addressed?*

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.

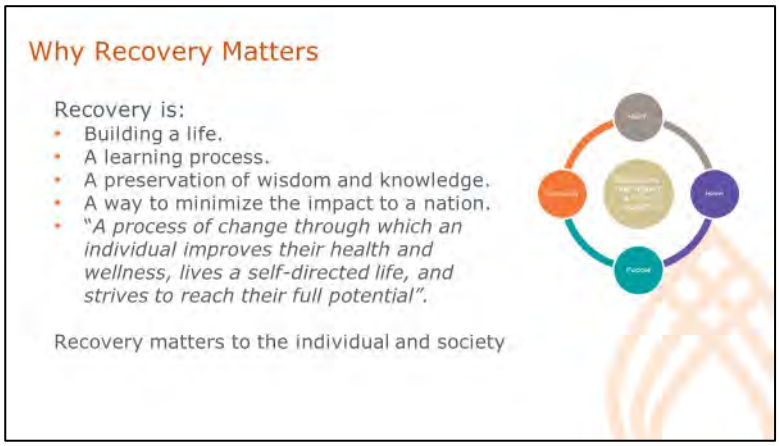
Scenario #4 (Content Warning)

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.

Slide #32: Why Recovers Matters



Explain: To stop using a substance and to recover from a substance use disorder are two different things.

- Not using anymore means a person discontinued using a substance.
- Recovery means working on a life that the individual feels in control of and fulfilled by.
- It is a paradigm shift from dependence on unhealthy coping skills to the building and use of healthy coping skills. Recovery is where a new life is built.
- Recovery is a profoundly meaningful process.

(Levis et al., 2021)

However, recovery is not a linear process. In recovery relapse is part of the picture because recovery is a learning process. To slip, to fall, to slide backwards is part of the process. When the person experiences a return to previous behaviors, also known as relapse, they have to work on figuring out what went wrong, revisit strategies that had been working, and re-adjust their recovery.

Remind participants of SAMHSA's working definition: "*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".*

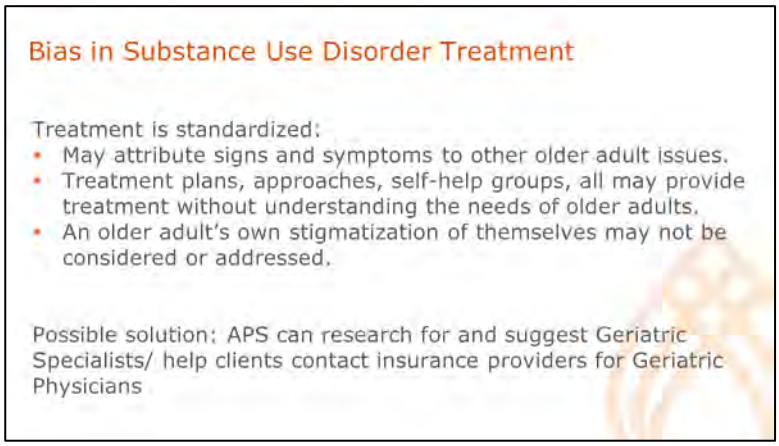
Explain:

Recovery matters to the individual as well as society.

- Recovery matters to individuals who stop using when they get "sick and tired of being sick and tired. Older adulthood is a time when this is more likely to occur because the negative consequences may be combined with the factors of aging, which places a heavier burden on the individual.

    - Change can become more desirable because of these consequences. The barrier to their recovery can be the lack of hope, the strength of the feeling that they are trapped and powerless.
- Recovery matters to our society, to all of us because older adults have lived our history, they have preserved our diversity, our many cultures. They have gained wisdom as they worked their way through life, wisdom others can grow from. Ageism is very real and the contributions of older adults are often not valued as they should be. Still, when our society loses an older adult to a substance use disorder it comes at a cost to all of us.

Slide #33: Bias in Substance Use Disorders Treatment



Explain: We have discussed Ageism in society. Ageism is also enacted in the medical health community. As we have seen, the Diagnostic Manual (DSM) is not necessarily structured for diagnosing older adult substance use issues. In addition:

- Providers may attribute signs of substance use issues to common aging issues, or even medications that are prescribed; problems with memory loss and confusion assigned to neurological disorders, falls and physical injuries attributed to increased mobility issues.
- Research on recovery from substance use has been mainly done on younger adults, so once again diagnosed standardized treatment often excludes the needs of an older adult with.
    - Treatment plans, approaches, self-help groups, all may provide treatment without understanding the needs of older adults.
- The older population grew up in a time when substance use and mental health issues were often seen as a moral failure, a refusal to "be an adult," or "be responsible."
- Unless someone is a geriatric specialist or has a background in gerontology, few providers are trained and educated in older adult substance abuse recovery.

A possible solution for APS professionals can be to find out what geriatric physicians exist in their local area.

- This can be done by helping a client contact their medical provider to ask for geriatric physicians, or by web searches, or by making contact with provider groups.
- The APS professional can ask to help with the call, as often there is some trepidation about calling on one's own, which results in a continual postponement of making that call. It can be pointed out to the client that

the APS professional can provide them a back-up to asking questions, catching all of the information, and writing it down.

As a side note, it is common for older adults to have loyalty to their current doctor. If they are willing, they can go to a geriatric specialist for an initial consult, and depending on their insurance may be able to retain both doctors past that consult.

(Morgan et al., 2011)

(Chhatre,et al., 2017)

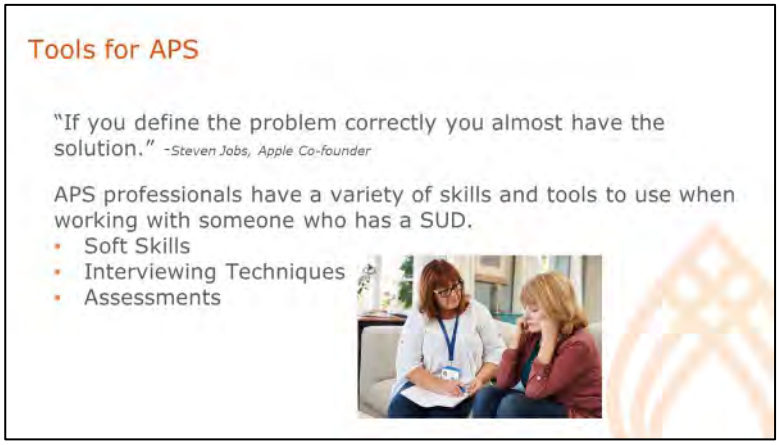
Interviewing and Assessments

Time Allotted: 15 minutes

Associated Objective(s): Summarize SAMSHA's 10 guiding principles of recovery as they apply to working with those served by APS

Method: Lecture, large groups discussions, chat feature

Slide #34: Tools in APS



Ask for a volunteer to read the quote on the slide.

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

Explain that APS professionals come from a variety of backgrounds, education and experiences and have a variety of tools to pull from including:

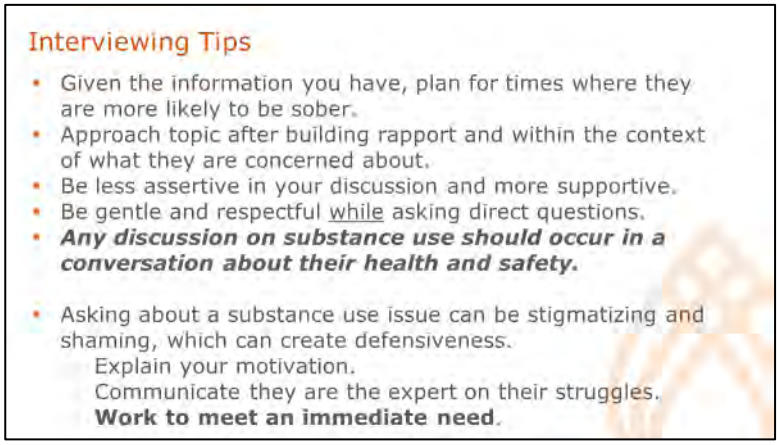
- Soft Skills
- Interviewing Techniques
- Assessments

Unless designated to do so in your role in APS, you will not be diagnosing or providing treatment for people you work with. However, as with all clients; interviewing, assessing, and developing collaborative service plans with appropriate interventions are some of the responsibilities for APS.

The next two sections of this training will cover interviewing skills and assessments.

<u>Trainer note:</u> There are other trainings that focus on a variety of interviewing techniques. This section is condensed to enhance what interviewing techniques APS already use and tailor to those who are experiencing substance use or misuse.

Slide #35: Interviewing Tips



Share: When an APS professional is meeting with a client, there has already been a report and there is an existing idea of what may be occurring in this person's life. The APS professional's primary tasks are to assess both risk and decision-making ability and to provide options for interventions and resources that may improve someone's safety and well-being. When there is a possibility of a substance use disorder keep in mind the SAMHSA Principles and be aware of some basic rules of interviewing

If you are able to, determine a best time to visit for either initial or follow up visits. Consider when they are most likely to have the most clarity (be sober, or the least high/drunk). This will facilitate your ability to consider their decision-making ability as well as build rapport and maximize your safety.

Given the information you have, consider:

- What days are best (least likely to be high or drunk)?
  - Do they have regular appointments or commitments where it's likely they will be sober? Plan around those appointments.
- What time of the day is best?
  - Are you aware of any patterns of when they use substance? Plan around them.

When meeting with the person:

- Approach the topic after building rapport and within the context of their concerns.
- Be less assertive in your discussion and more supportive.
- Be gentle and respectful while asking direct questions. The tone of voice makes a big difference in sending a message that the person is not being judged.
- Asking about a substance use issue can create defensiveness.
  - Explain your motivation.

    - Keep any discussion on substance use in the context of a conversation about their health and safety.
    - Make it clear that you understand they are the expert on their experience.
- With your interventions, work to meet an immediate need.
- Individuals with a substance use disorder <u>often</u> do not want to discuss it with people who do not have personal experience of the disorder. They may want to know if the APS professional has ever had a substance use disorder themselves. If this comes up:
    - Communicate that it makes sense they would want to know this. Share that you have ideas, thoughts, or some understanding that can be helpful once you *better understand their story.*
    - You do not need to disclose if you are in recovery.

(Keurbis et al., 2014)

(*APS TARC- Substance Abuse Resources,n.d.)*

Explain:

We are going to look at a few simple assessments tools that are often used as a prescreening, or for the beginning of a brief intervention.

- A clinical assessment would be much more in depth, these are brief assessments that can be used to assess if there are indicators a problem exists at which point a client would be referred to someone who can assess and treat.

Note that bias towards older adults is also seen in the assessment tools. While there are multiple brief assessments to assess for substance use, and we'll cover three of them. Only one is constructed to assess older adults. That is SMAST-G, which is adapted from the MAST.

Share the following content warning:

- If anything hits close to personal life in an activating way please feel free to put me on mute or step away.

Your organization's Employee Assistance Program may have confidential resources available if content is activating.

Slide #36: CAGE Assessment

Share that the first short assessment APS professionals can use to indicate whether there are needs for referrals or not is using four (4) questions from the Cut down, Annoyed, Guilty, and Eye-opener Tool or CAGE (or CAGE-AID) Assessment.

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

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)?

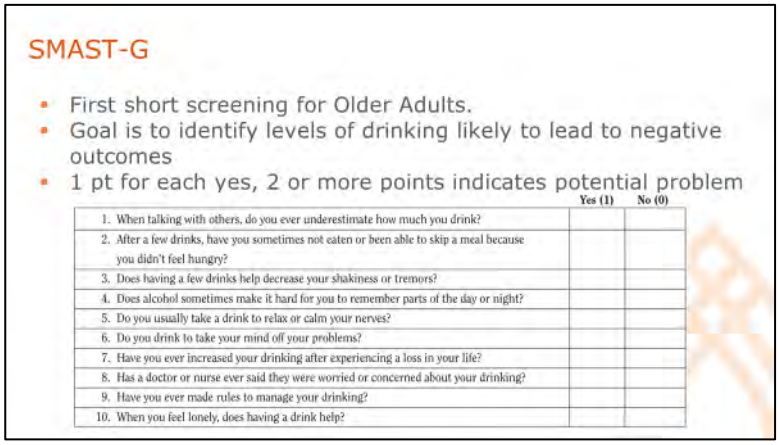
Scoring: Item responses on the CAGE questions are scored 0 for "no" and 1 for "yes" answers, with a higher score being an indication of alcohol or drug misuse.

- A total score of two or greater is considered significant.

If you were to ask these questions, make it part of the conversation and take out the alcohol or drug reference. Remember if you are assessing alcohol use and you put the “drug” word in, you may raise defensiveness as alcohol is more socially acceptable.

CAGE Substance Screening Tool.pdf (hopkinsmedicine.org)

Slide #37: SMAST-G Assessment



Explain: The Shortened Michigan Alcohol Screening Test—Geriatric Version also known as the SMAST-G is the only assessment to focus on older adult substance use.

- It was adapted from the original, titled MAST, to focus on older adult substance use. The focus is on alcohol because that is the most likely substance for older adults to be using.
- This is for assessment of potential misuse of substances only—not to be used as anything more than an indicator of need for further assessment, diagnosis and treatment.

(Naegle, 2012)

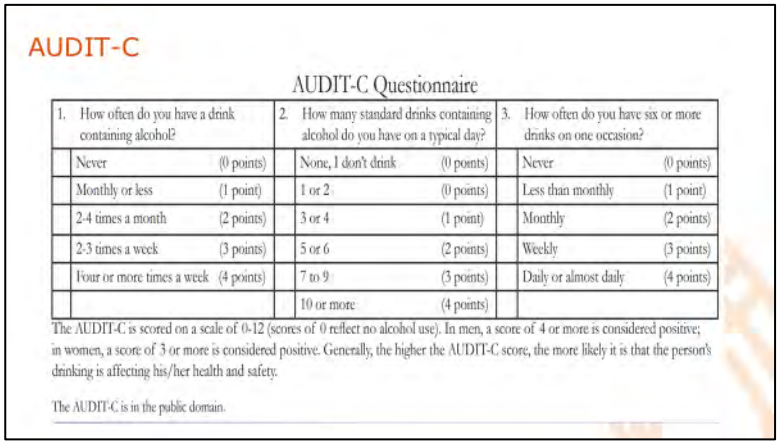
<u>There are 10 yes/no questions:</u>

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 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?

EXTRA QUESTION: Do you drink alcohol and take mood or, mind altering drugs, including prescription tranquilizers, prescription sleeping pills, prescription pain pills, or any illicit drugs?

There is a score of 1 point per “yes” and 2+ points are indictive of alcohol misuse. The extra question is not scored, but can be asked.

Slide #38: AUDIT-C


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.

Explain: The Alcohol Use Disorders Identification Test-Concise, AUDIT-C, is a brief screening instrument that can identify hazardous drinking. It is modified from the 10 question Audit Instrument.

There are three (3) questions with a point scale for each question:

1. How often did you have a drink containing alcohol in the past year?
2. How many drinks did you have on a typical day when you were drinking in the past year?
3. How often did you have six or more drinks on one occasion in the past year?

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 their health and safety.

Share that APS programs might have other assessments or policies in place for participants to use when working with people who use or misuse substances. Some of these questions from the assessments can be used in collaboration with various other interview techniques.

The answers to some of these questions might help inform some of the interventions APS uses or suggestions with people they work with.

Interventions

Time Allotted: 90 minutes

Associated Objective(s): Explain three interventions that can be used to create a collaborative service plan with someone experiencing a substance use disorder.

Method: Lecture, large groups discussions, chat, Case Scenario and breakout groups.

Slide #39: Person-Centered Interventions and Service Plans

Explain: As in all APS work, there is a task to balance the person's right to self-determination (making their own decisions, even when we may not agree) and their right to safety. This remains the same when suggesting or providing interventions with someone who uses substances.

In developing a plan and identification of services the APS professional will:

- Identify safety and medical needs
- Assess the decision-making ability to accept services.
- Identify referral's for treatment from other providers.
- Identify protective factors—some of which will have been diminished or stopped as the substance use disorder takes over their functional abilities.

The goal is to gain voluntary acceptance instead of rejection by the individual, and to help them with mental or medical health treatment, support services, etc. The best chances for successful engagement, occur when the plan is kept person centered which is best done by:

- Understanding their perception of situation, including their wishes and motivation.
- Using the client's strengths to address situation.
- Knowing what services and resources are available.
- Identifying their pattern of use and what can help them to change it, be that harm reduction or abstinence.

(Barry and Blow, 2016)

Slide #40: Interventions: Challenges

Trainer note: this slide is animated.

Explain: We've discussed some of the challenges you will find in working with individuals with substance use issues; the lack of research and informed service provision, the stigmatizing of substance use treatment. We also need to remember the more casual attitude that will grow with the baby boomer cohort towards substance use. The normalization of the use, the right to use, especially when endorsed by the idea that time is running out.

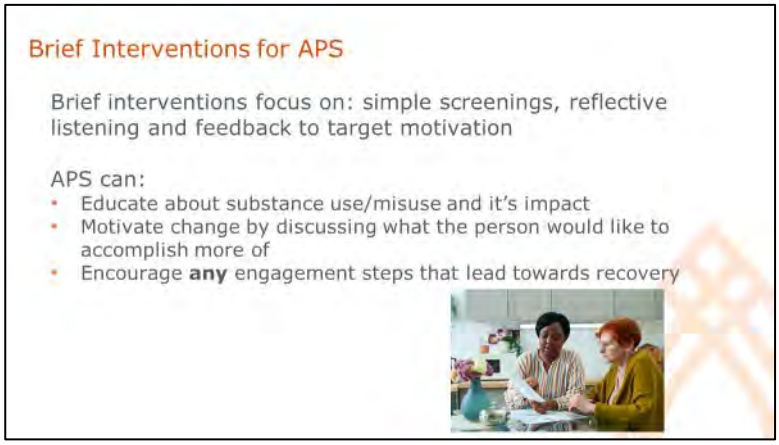
However older adults, particularly if they are in a "at risk" stage, can often benefit from simple and brief interventions, more so than a younger population.

Share the following elements of a brief intervention. (*Used with permission by the VA Office of Quality, Safety, and Value*)

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

Follow up visits after the brief intervention, or helping the client engage in other services will support the reduction of risk and increased safety.

Slide #41: Brief Interventions for APS



Explain: These basic brief interventions which focuses on simple screenings, reflective listening and feedback can target the motivation and method for reduction, or help the client consider removal of risk factors, which can lead to increased safety and well-being. This is something that APS professionals can accept as a "success" when they may only see a client once, or a few times.

Possible pathways to brief interventions that APS professionals can use are:

- Educate about substance use. There is often a lack of comprehension about the issue and its impacts.
- Motivate a client to consider change by discussing what they might want to accomplish more of. Are there changes they would like to make?
- Encourage **any** engagement in steps that lead towards recovery, or creates competition to substance use. (Discussed more in Motivational Interviewing).

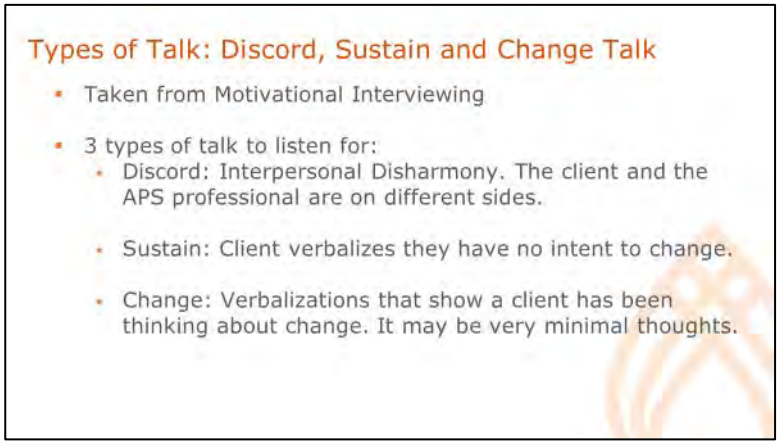
(Keurbis et al., 2014)

(Roux et al., 2016)

Explain that the next few slides we're going to provide many types of interventions. Remind participants that the person, their situation, the amount of time APS has with them, the risk factors, resources available, etc., will all impact what interventions are suggested or used and reflect back to SAMHSA's Recovery Principle of Many Pathways.

One important aspect of deciding on which interventions to identify or implement, is determined by where the person is at themselves. APS can gain insight into this by identifying the types of talk a client might be sharing.

Slide #42: Change, Discord and Sustain Talk



Explain: When talking to a person during an interview about substance use there are three types of talk you may hear: Discord Talk, Sustain Talk and Change Talk. You want to develop an ear for which one that you are hearing, because it helps determine how to respond in a way that facilitates rapport and builds communication, which of course, creates best collaboration. This is part of motivational interviewing, something that will be discussed later, but for now let's define these types of talk as how you can facilitate an interview.

Discord Talk: Interpersonal disharmony.

- This happens when someone tries to persuade, confront, or be an expert of another's life. It encourages two sides, with each person arguing for their side.
- APS professionals can enter a situation where this has been set up, by others, or the situation. They can also participate in creating the situation.
- Discord talk sounds like: Arguing, Interrupting, Ignoring, Discounting. It can even sound like agreeing, but the agreeing is done to end a conversation and it is not genuine.

Sustain Talk: Any verbalization that indicates the client plans to keep current behavior.

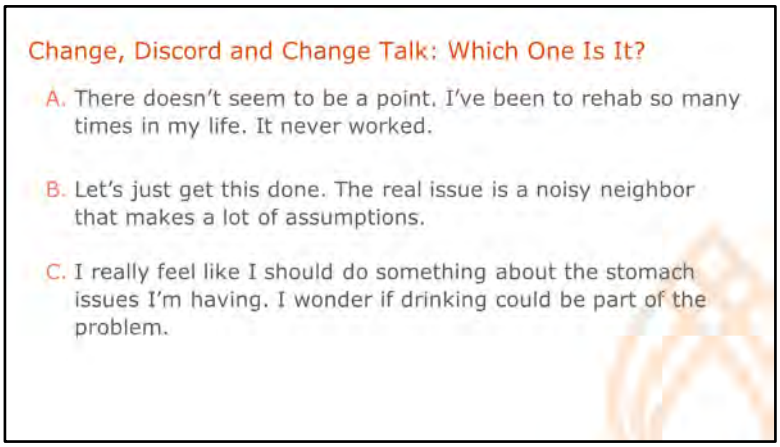
- Defending the behavior, explaining why there is no other option.
- There are many reasons for this, among them the client may genuinely not perceive a need for change, they may not feel it's possible, or they many simply not want to change.

Change Talk: The one we need to be very attuned to because that provides us a door to carefully walk though.

- It shows a person is thinking about change and is possibly willing to discuss how it might happen.
- Important to understand is that there are *different degrees of resolve with change talk*.
- Early change talk can mean little more than they are thinking about it, but not particularly committed. More advanced change talk shows a though process that has begun to determine why they want to change, or how they will change.
- Your task is to recognize it and encourage it.

(Dempsey, Kristen and Hall, Ali, PESI)

Slide #43: Change, Discord and Change Talk: Which One Is It?



Activity #4 (Part 1)- Identifying Talk Type (3 minutes)

Individual, Large Group

Trainer note: This slide is animated.

Instructions:

1. **Provide** the statements below and **ask** participants to identify (either by chat or as a poll function) which type of talk they believe it to be.
2. **Explain** that we might fluctuate in deciding if something is discord, sustain or change talk depending on inflection and tone.
    a. **Restate** the statements after changing your inflection and tone and **ask** if they would change their answers.

A. "There doesn't seem to be a point. I've been to rehab so many times in my life. It never worked." (Inflection can suggest discouragement which is sustain talk, or anger which would be discord).
B. "Let's just get this done. The real issue is a noisy neighbor that makes a lot of assumptions." (Inflection can suggest annoyance/quickness which would likely be discord, or with honest attempt/acceptance which could be change.)
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." (Change talk when said with sincerity, or inflection could be patronizing and then might be discord.)

(Dempsey, Kristen and Hall, Ali PESI)

Slide #44: Video: Successful Initial Home Visit, Self-Neglect

Activity #4 (Part 2)- Video Demonstration (15-20 minutes)

Individual, Large Group

Explain: Listening for types of talk takes practice. Let's look at a video. As you watch the video think what statements reflect discord, change or sustain talk, and how the APS professional responds to them.

Show the APS Training Video: Successful Initial Home Visit, self-neglect-YouTube (7:14-10:39) and then **discuss** the prompts below.

1. Listen for change, sustain and discord talk.
    a. *"I don't need support" (likely sustain)*
    b. *"If it means it will speed things up, I'll get the papers for you" (likely discord)*
    c. *"What I was told to eat, is not what I as a grown man am going to eat". (likely sustain or discord)*
    d. *"I read somewhere wine is really good for your heart". (likely discord)*
    e. *"Hey, you come in here and ask me questions about my life; what I eat, and what I drink". (likely discord)*

2. How did the APS professional answer the different types of talk?
    a. What were their strengths?
        i. *Possible answers:*
            1. *Asking if he knew why the doctor made recommendations*
            2. *Offered the possibility of slowly introducing some change behavior*
            3. *Validated his strengths and independency*
3. When discussing the bottles of wine:

a. What were some of the strengths of the APS professional?
    i. *Discussing the wine drinking in relation to his health (his heart).*
    ii. *Starting off with a large amount (3-4 bottles) to avoid shame talk.*
b. What are some areas of improvement?
    i. *Explain their motivation for asking*
    ii. *Use some of the screening assessment questions in conversation*.

4. Is there anything you would have done differently?
    a. To assess for risk?
    b. To manage the different types of talk?

APS Training Video: Successful Initial Home Visit, self-neglect - YouTube

Or visit: https://theacademy.sdsu.edu/programs/apswi/apswi-videos/ and download the APS Training Video: Successful Initial Home Visit, self-neglect.

Slide #45: How to Respond to Talk Types

Explain: How an APS professional responds to discord or sustain talk can include:

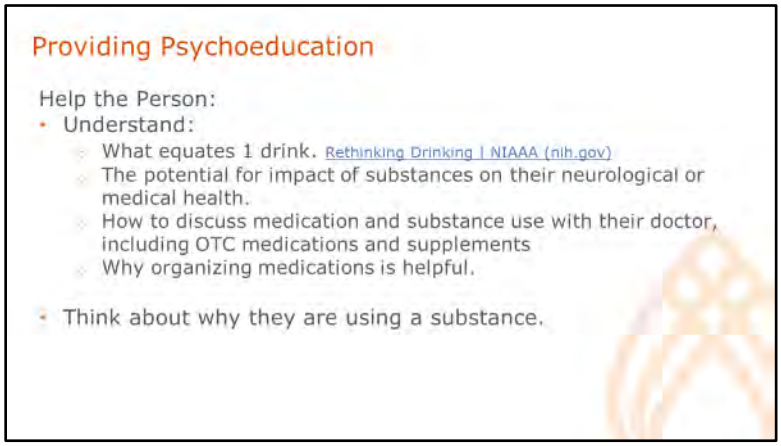
- Validating their perspective. Agree with what you can agree with. Find common ground.
- Pointing out the strengths you can see. Sometimes we see strengths and make note of them but forget to verbalize them.
- Supporting their self-determination. Help them understand you know they have the right to self-determination and you are present in order to help support them.
- Reflect back what you are hearing. This can be the hardest to remember to do. Say what you hear, "You have too much time on your hands and you wish there was more to do." You can always reflect back what you hear and move into asking how you can help, or explaining what you think you can do.

All of these, when done, can help create a sense of collaboration. It can come from asking questions such as, "How can I help you." How can we work together on this?"

(Dempsey, Kristen and Hall, Ali PESI)

Responding to change talk means to hear that desire to change, even when it is tenuous, and to elicit or pull out more from the client. How to help them further define and discuss changes they would like to make will be discussed when we talk about Motivational Interviewing. For now, let's look at other types of interventions that APS can offer, depending on the person and the situation. Keep the types of talk you might hear in mind as we review each.

Slide #46: Psychoeducation



Trainer note: this slide is animated to cover each dot point and provide additional explanation from your experience if desired.

Explain: Having considered how to successfully interview let's talk about how psychoeducation can be used when it comes to discussing substance use and recovery. Psychoeducation allows an older adult to:

- Understand what "a drink" is—the amount of each type of alcohol that equates 1 drink. National Institute on Alcohol Abuse and Alcoholism (NIAAA) website provides information about this, along with a visual that can be cut and pasted so you can make a handout. What's a Standard Drink Measurment? - Rethinking Drinking | NIAAA (nih.gov)
- Learn about potential harm from substances, particularly with their neurological or medical health which can be of great concern to older adults.
- Know how to discuss medication and substance use with their doctor, or just having the confidence to do so. Older adults may have an element of shame about a discussion with the doctor over medications, or substances they believe they are overusing which you as an APS professional can discuss with them.
- Teach the importance of communicating to their physician everything they take, over including the counter medications and supplements.
    - Many things can interact in harmful ways; food, supplements, OTC meds.
- Understand why organizing their medications so they are taken properly is helpful.
- Helping them consider why they are using a substance.

Understand the importance of discussing Cannabis use with their doctor as little is understood about safe use.

Slide #47: Encourage Discussion with the Primary or Geriatric Physician

Explain: Another simple intervention that can be made is to encourage and facilitate a discussion with their primary physician.

Older adults are more likely than a younger adult to seek help from their primary physician, or a specialty care provider, in part because they are more likely to be experiencing the consequences of their substance use. A primary physician may be the first medical personnel they discuss any concerns or issues with about substance abuse. Research has shown that a large number of older adults living with alcohol use disorder can have a positive response to an intervention from their primary physician and be motivated to change when health and lifestyle are addressed in medical settings. The “at risk” population is often very treatable with visiting their physician, having a discussion, psychoeducation and ideas they had not considered previously.

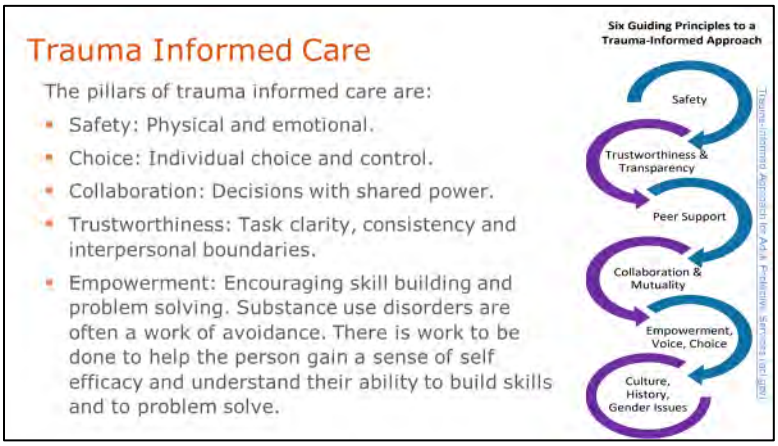
This is an intervention an APS professional can facilitate by aiding a visit to the client’s a primary care physician with a follow up on how it went.

- Barriers to services should be inquired about and addressed.
- If individuals are not following through on tasks, realize the possibility of a barrier instead of attributing it to lack of motivation. Sometimes professionals can lay out a plan they see as simple and one the client does not.
- This is also where the idea of visiting a geriatric physician can be addressed and if the client is open to it, working on locating and scheduling an appointment to one.

This is part of person-centered treatment, to create a plan with them that they can follow, or ask for help with.

(Barry & Blow, 2016), (Schonfeld et al., 2015), (Fagbemi, 2021)

Slide #48: Trauma Informed Care



Review: 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. Remember because the individual has focused on escape and avoidance you can help them build problem solving skills and gain a sense of self efficacy which is tremendously empowering in recovery from substance use.
- Culture: Seek to understand the history, identities and experience of people.

Explain: Trauma, as previously discussed can cause excessive physical and mental wear and tear and initiate individuals into engaging in unhealthy choices. Understanding trauma triggers or what activates certain responses is a task to be worked on by mental health professionals. They can help the client identify and understand what their triggers are and how to use replacement strategies. An APS professional can help a client engage in getting the help they need to do that.

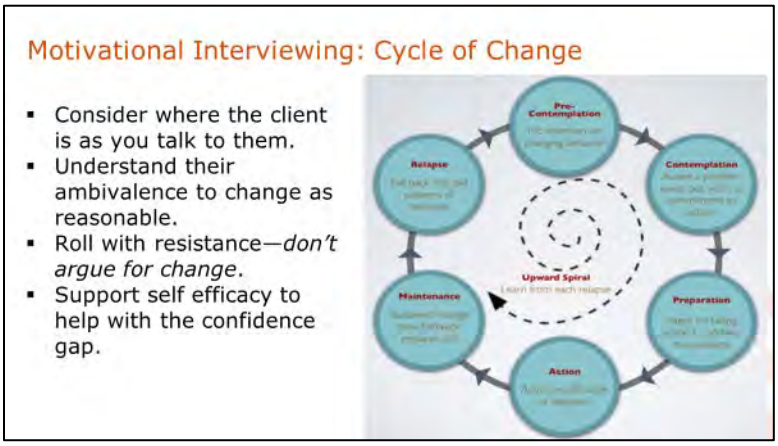
Seeking Safety is an evidenced based group that deals with trauma and substance use. When linking people to mental health services, ask providers if that group is provided. This provides a support group as well as learning more about managing trauma responses.

Bolstering social support can help decrease the negative influence of trauma:

"Positive relationships are necessary for healthy human development, but trauma undermines these life-giving connections. Although the importance

of positive relationships has long been recognized, there is now good scientific evidence from human services that these are the critical ingredients in healing and growth." (Bath, 2008, p. 19)

Slide #49: Motivational Interviewing: Cycle of Change



<u>Trainer note:</u> this slide is animated to first review the cycle of change.

Ask: Can I find out how many of you have heard of, or know about Motivational Interviewing?

Explain: Motivational Interviewing is a huge subject, so we are touching on it here to give participants an idea of how it can be used. This is far from comprehensive.

Ask: Pick something about yourself you would like to change. Anything, more organization, better exercise habits, losing weight, eating healthier, quit smoking—something you would make a New Year's goal to do. Keep that in mind as we discuss Motivational Interviewing.

Explain: We all go through a process when we are trying to change something about ourselves. Individuals will go forward and slide backwards. There are times of high motivation and times of feeling defeated. The most important task is to remember change is a process *<u>and all steps count</u>*. The slide backwards is inevitable and can be learned from. As a note, that slide backwards is called relapse, but is better said as "a return to previous behaviors."

Review: The cycle of change.

- An APS professional can consider where they see the client as being in the cycle as an important part of how to work with them. A client who is **pre-contemplative** and not even considering change won't be someone you ask about change of coping strategies. You will probably be hearing discord talk, sustain talk, or a mix of the two.
    - Instead you can ask about what could provide competition; what activities they enjoy doing and how often they get to do

them. This will help to get an idea of what might be useful in recovery and what may have been decreased or given up.

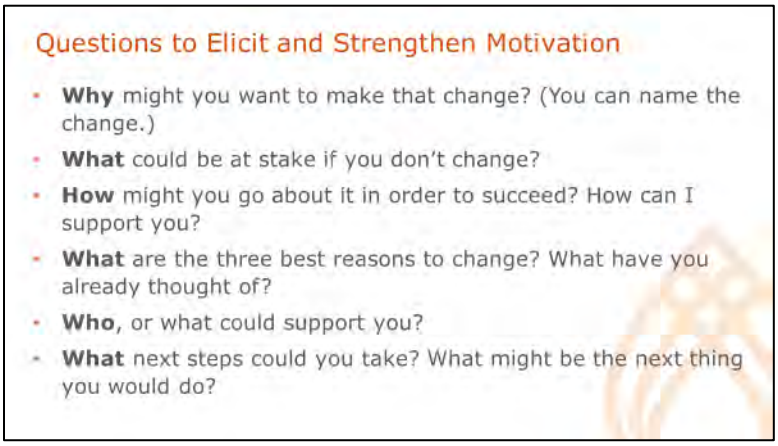
- If a person is in the **contemplation** stage you will hear some beginning change talk and you will seek to strengthen it. *The point is to ask the right questions for the stage the person is in.* We will be reviewing questions you can use. As we do that think about what stages those questions fit best in.
- One of the more important things to remember is that when the person is contemplating change they are often ambivalent about that change. It is reasonable and realistic to have this ambivalence. The substance has benefitted them. It may stand in their mind as being their best support in difficult, painful times.
  - We humans have what is called a "righting reflex" where we want to make sure others stay on track with our perception of what is best for them. When you hear that ambivalence about not using a substance, accept it with empathy and focus on building a collaborative relationship and a safe space.
    - Do not argue for change because you then create two sides and the other side will be to argue for no change.

(Lehmann& Fingerhood, 2018)

- Preparation stage is of course where you will hear more defined change talk because the person has made a commitment to change and is thinking out steps. You can help them define those steps more clearly and concretely. If they say,"I plan to go a 12 step meeting" can be met with validation and collaboration; "That is great, do you have a list of meetings?", "How I can support you?"
- Action and Maintenance are self-explanatory.
- Relapse is rebuilding. Solution focused, which we will talk about next can be helpful for rebuilding.
- Let's move on to look at Motivational Interviewing Questions that could be helpful. As we look at them consider what stage you would use them in.

(Miller, W. R., & Rollnick, S. 2012)
(Littrell, 2011)

Slide #50: Questions to Elicit and Strengthen Motivation



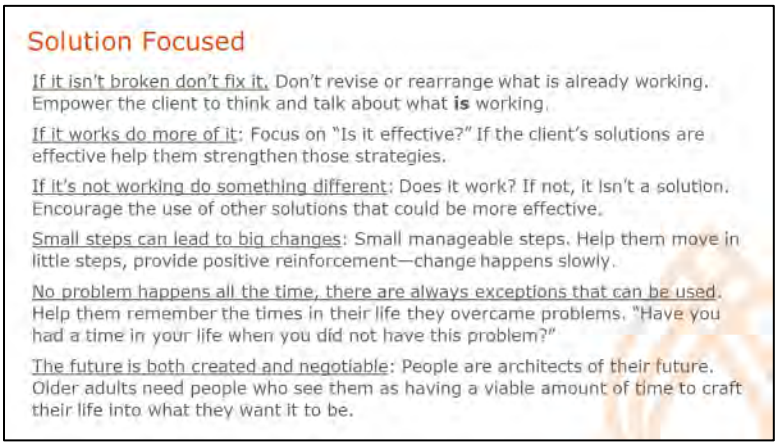
Trainer note: this slide is animated to review each question and add your own examples from your experience, if desired.

Share the following questions to elicit and strengthen motivation:

- **Why** might you want to make that change? (You can name the change; why might you want to stop drinking in the morning.)
- **What** could be at stake if you don't change? What are the three best reasons to change? The three most important reasons to make this change? (Or 2, or 1—gage the appropriateness.)
- **How** might you go about it in order to succeed? What have you already thought of? How can I support you?
- **Who**, or what could support you.
- **What** are the next steps could you take? What might be the next thing you would do? What resources are out there for you?

Motivational Interviewing is a way to create a safe supportive place for a client to collaborate on a safety plan. There is much more to learn about motivational interviewing than can be covered in this presentation. One additional resource can be found at SAMHSA, Tip 35 Enhancing Motivation for Change in Substance Abuse Treatment. [TIP 35: Enhancing Motivation for Change in Substance Abuse Treatment | SAMHSA]

Slide #51: Solution Focused



Trainer note: this slide is animated to review each tenet.

Explain: Solution focused therapy builds on the idea that everyone has had successes in their lives and can use those successes to further succeed. There are simple questions to ask that can help a person use strengths and qualities they already have.

- It is a group of ideas that is future focused and goal directed. It comes from philosophy, from Buddhism, from many things.
- It is a practical and empowering. It is likely to seem familiar to an APS professional who often is using a strengths-based approach with all clients.

The Overarching Tenets: Incorporating them into the way you think as you safety plan with a client is a big skill development. Begin to think through the frame of solution focused.

If it isn't broken don't fix it. Do not become tempted to revise or rearrange a life before you know what is working. There are always aspects of life that are working for a client and can be used to solve a problem. It empowers a client to think and talk about what those are. So your focus can be on, "What is working for you?"

If it works do more of it: Place focus on "is it effective?" If the client's solutions are effective work with them on strengthening those strategies. What the client finds useful may not be the solution an APS professional would want them to use. One thing to understand with substance use is that people in recovery often begin with practices that are a reduction of unhealthy, and as their ability to be in recovery grows they make better decisions.

If it's not working do something different: No matter how brilliant a solution is, it's only as good as it's effectiveness. Does it work? If not, it isn't a

solution. Remember the definition of insanity is to repeat an action over and over when it is not working. Humans have the tendency to do that. 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 and allow change to happen as change does, very slowly.

No problem happens all the time, there are always exceptions that can be used. The client has had times in their life when they overcame problems including times of sobriety. Ask questions such as, “Have you had a time in your life when you did not have this problem?” By helping them to focus on times when they have been successful, or sober, an APS professional can help a client to identify what helped them in those times and this can provide solutions and help the client to realize that change is possible.

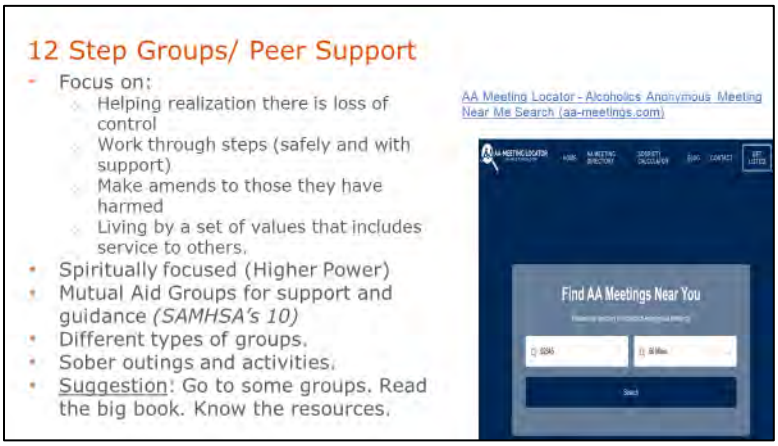
The future is both created and negotiable: People are architects of their own future. If a client is trapped in the, “It’s almost over so I may as well do what I want” they need to consider what they still have a desire to accomplish. Older adults need people who see them as having a viable amount of time to continue to craft their life into what they want it to be. And to help them embrace the necessary steps.

(De Shazer & Dolan, 2012).

(Littrell, 2011)

One of the strengths of solution focus discussion is that the overall discussion tends to be more positive as the APS professional helps the client focus on how they have been successful and help them realize they can create their own solutions and make their own decisions.

Slide #52: 12 Step Groups/ Peer Support



Trainer note: this slide is animated.

Explain: The original was Alcoholics Anonymous (AA). 12 step groups provide a spiritual foundation in a recovery program. The 12 step groups include Co-Dependents Anonymous and Al-Anon, Alateen; groups for family members of people with substance use disorders. The 12 step groups focus on:

- Helping a person realize they have lost control of their lives and need the help of a higher power.
- Working through the steps.
- Make amends to those they have harmed
- Living by a set of values that includes service to others.

The groups are spiritually focused and while a person does not have to believe in God, they do need to define and depend on a higher power typically outside of themselves, but they can define the higher power as something inside of them.

These are a type of mutual aid groups, which are mentioned in the SAMHSA principles of recovery. They provide social support and guidance for a new way of life. Anyone is welcome, including those under the influence, although if that is the case, the person is asked not to talk in group.

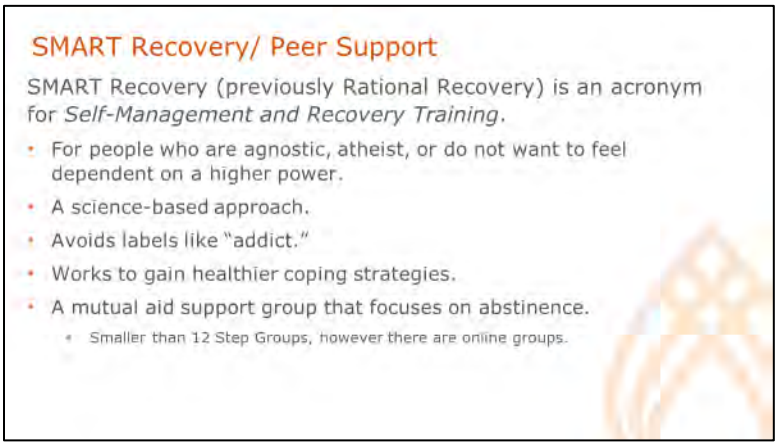
There are different types of groups; women's groups, big book study groups and so on. They also do many sober activities so that people can build a sober support group. These groups are widely used by courts and addiction recovery programs and have been highly influential. The easiest way to find a group is to go online and locate a phone number to call, or search for a meeting. Also check your senior citizen centers who may provide have AA meetings in their facility.

Part of providing referrals to people is knowing what they are really like.

- One suggestion for APS professionals is to go to a 12 step group (or a few). Get a list of their meetings, go to one, look at their materials when you are there. Pick up the big book and read it. Learn about them and how they function so you can knowledgeably discuss with a client.

Have a problem with alcohol? There is a solution. | Alcoholics Anonymous (aa.org)

Slide #53: Smart Recovery/ Peer Support



Explain: Previously Rational Recovery, SMART Recovery is an acronym for *Self-Management and Recovery Training*.

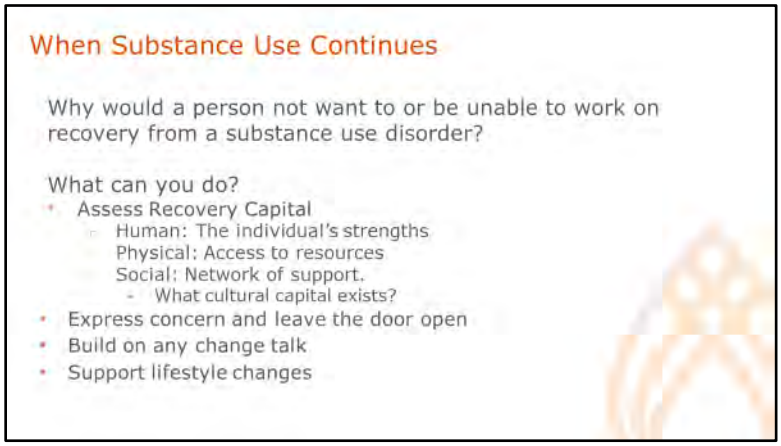
- This group was started for people who were agnostic, atheist, or simply did not want to look at recovery as being dependent on a higher power.
- Instead the focus is on the power of the group and having a science-based approach. It also avoids labels like “addict” and acknowledges that substance use is a coping strategy that is ultimately self-destructive. It is present focused and works to gain new and healthier coping strategies.

As with the 12 step groups it is also mutual aid support group that focuses on abstinence from addiction. There are fewer in-person groups as Smart Recovery is a smaller entity then 12 Step Groups, however there are many online groups.

Again, a suggestion is for an APS professional to attend a group and understand it’s dynamics in order to make person-centered referrals.

SMART Recovery

Slide #54: When Substance Use Continues



Validate APS will work with people who communicate an acceptance of their substance use and even a desire to continue using/misusing despite knowing the risks.

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

- *Possible answers: Discouragement. "Time is running out" thinking. Medical and/or mental health challenges. A perception that what they must sacrifice is not worth it. Denial of the problem.*

Explain: On the heels of the idea "time is running out" is very possibly another problem, the lack of self-efficacy—the individual's belief they are unable to quit. The person does not believe in their own ability to let go of the substance use.

Reflecting back on SAMHSA's 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", what can an APS professional do in these situations?*

- Support everything the person is doing that is good, healthy and helpful to them. And consider what recovery capital they have to available to engage in doing healthy and rewarding activities.

Define: Recovery capital: "Recovery capital domains include physical, social, human, community, and cultural resources that are thought to support or detract from recovery. Recovery capital theory suggests there is no 'zero' level of recovery capital within each category, as every person has varying amounts of resources afforded to them, and each form of capital reflects a unique continuum for every individual (Cloud & Granfield, 2008)."

The idea of recovery capital was first formulated as a way to understand those who had a "natural" or spontaneous recovery, without the help of professionals. Groups of individuals who had been able to do this were studied to better understand how they made the change.

Explain: Let's consider the three categories of recovery capital.

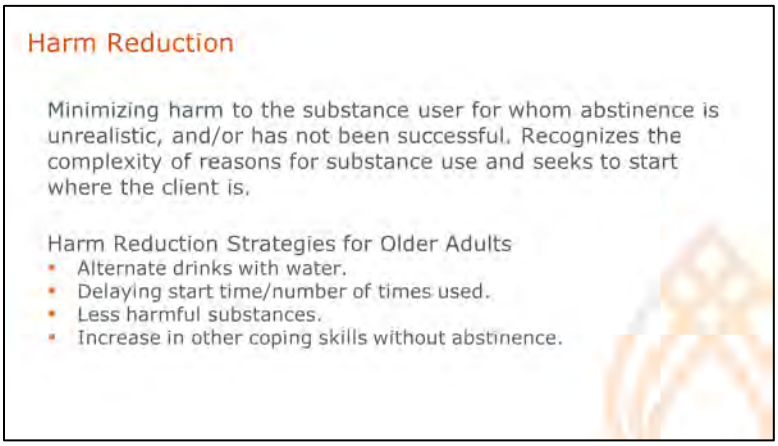
- Human Capital: Everything the person is. Age takes away some forms of human capital and tends to strengthen other forms. Health consequences are something that decreases human capital, whereas resiliency and emotion regulation are often increased with age.
- Physical Capital: Access to resources such as housing, medical help, and transportation that ensures their needs to recover are met. Housing security is a major factor of physical recovery capital, as is transportation to meet health needs. While these are types of resources are always limited an APS professional is more likely to know what is, and what is not, available.
- Social Capital: This is an individual's social connections, family and friends, which can help provide recovery capital in the form of resources and support. Because older adults can have a less social capital this is a type of capital that an APS professional can seek to increase by asking about and encouraging use of social resources, or encouraging use of new ones.
    - A form of social capital is cultural capital. An individual's culture may view substance use as a social norm, or may view seeking help as a sign of weakness. Strong cultural ties can also provide recovery capital.

As an APS professional, consider what recovery capital a person might have and how you can either work to remove barriers, or build on recovery capital that can be of use. This can be done for both those who are recovery minded, or people who are not ready to change at that point. Assessing an individual and applying the NAPSA and SAMHSA Principles is something that can be done with all individuals.

Other strategies an APS professional can work with are too:

- Express concern and leave the door open.
- Build on any change talk.
- Support any healthy lifestyle change.
- Remember there are many elements to the path of recovery and any steps in the right direction moves a person towards recovery.

Slide #55: Harm Reduction



Share that another evidence-based intervention for those with Substance Use Disorders is Harm Reduction.

In it's simplest form, it means minimizing harm to the substance user for whom abstinence is unrealistic and has not been successful.

- It recognizes the complexity of reasons for substance use and seeks to start where the client is.
- There is a wide spectrum of ideas and practices about harm reduction from supervised consumption to sobering centers to simple practices, such as watering down alcohol.
- One example would be the individuals with substance use disorders that use more damaging substances such as methamphetamine, or opiates, but have been able to make their primary drug something less harmful, such as cannabis.
    - Particularly with older adults some studies have documented how older adults have transitioned to cannabis use for pain management and decrease the risk of managing chronic pain with opiates. Those studies also found that medical marijuana laws correlated with decreased opiate overdoses.

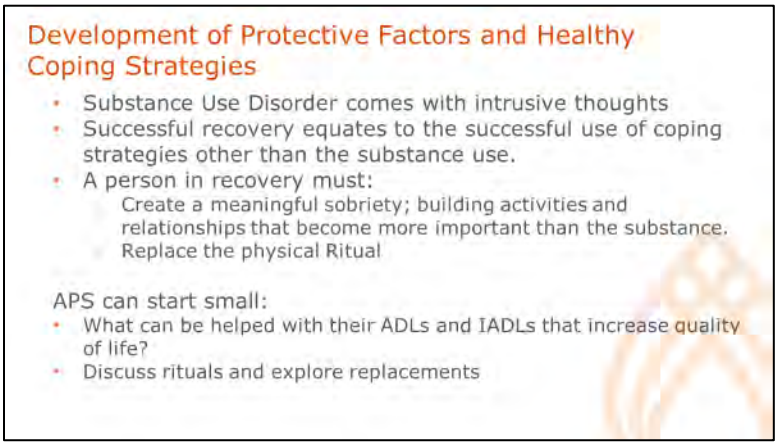
With older adults, who often respond well to basic interventions, Harm Reduction could be providing a brochure like "Rethinking Drinking" or tips to reduce the harm, such as eating before drinking, alternating with water, or diluting alcohol, creating a tracker, or making a safe drinking plan.

(Lau et al., 2015)

(Perera et al., 2022)

Harm reduction may be a good example of how people have to choose their own path and the APS professional's task is to work with them on doing so.

Slide #56: Development of Healthy Coping Strategies & Protective Factors



Trainer note: this slide is animated.

Explain: In line with recovery capital is the idea of building healthy coping strategies. A Substance Use Disorder is intrusive. The brain keeps focusing on the desire to use the substance. Over and over and over. The person has a sense of being at war inside their own head.

Explain: Intrusive thoughts speak like this.

> *"Use, it will help you."*
>
> *"Don't use, you can be strong."*
>
> *"I have to use."*
>
> *"No you don't. You are weak if you use."*
>
> *"Okay, I'll try not to think about it. I can do this instead" (using coping skills. Intrusive thoughts come back into head, get pushed out, come back, get pushed out . . . finally,)*
>
> *"I can't do this, I give up."*
>
> *Later, or the next day, "You blew it again didn't you?"*
>
> *"Yes, and what is the point of trying to stop? I can't even stop thinking about it, it never leaves me alone."*

Explain: A substance use disorder means an individual has cravings that are intrusive to their thoughts. Using the substance provides a brief escape from the thoughts, from negative affect, from life problems. For those people with mental health disorders it temporarily lifts the burden of depression, anxiety, or other mental health issues. *Successful recovery equates the successful use of coping strategies other than substance use.*

An APS professional can work on helping the person develop those coping skills. Help them build their problem-solving abilities, which in turns builds their sense of self efficacy. A question to ask can be; “Can you share with me some of your goals for the next three months regarding your physical and emotional health, your activities and hobbies, your relationships and social life, and your financial situation and other parts of your life? Any particular goals that are important right now?”

Help them build physical capital. Do they need help with basic and instrumental ADL’s that can increase quality of life? Are they able to pay bills, get groceries, make meals, scheduling appointments?

Proactively help them think out situations that can become triggers to substance use:

- Social isolation
- Boredom
- Pain
- Negative interactions.
- Environments that encourage or trigger substance use.

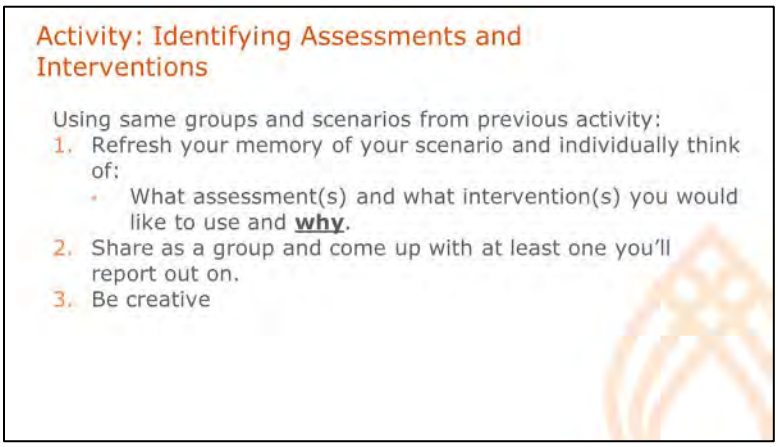
(SAMHSA substance use prevention)

(Kuerbis, et al., 2014)

Ask how they replace the ritual of substance use? Substance use is about ritual also, not just the impact of the substance. The smoker misses the smell, lighting a cigarette, raising it to their mouth and taking a draw. The drinker misses the pouring a drink, taking a swallow. Discuss what ritual the person will miss and what can help replace it. People who stop drinking often replace the ritual with chewing ice, drinking large amounts of soda and coffee, chewing on gum, eating candy. Different substances create different rituals. The client in recovery needs to think what they will miss and what can replace it. Sometimes the rituals are replaced by less than healthy choices—drinking soda after soda, eating a lot of candy. Remember that recovery is a process and the focus should be; Is the process progress?

There are many ways to help clients and as you find yourself in each situation with each unique individual and all their strengths and scars your ability to focus on the client, hear the needs of the client and collaboratively work with them is the common denominator of what helps a client. We are now going to work on using the previous vignettes to do an appropriately identify and consider use of assessments and interventions.

Slide #57: Activity: Identifying Appropriate Assessments and Interventions



Activity #5: Identifying Appropriate Assessments and Interventions to Case Scenarios (30 minutes total with 20 minutes for activity, 10 minutes for debrief)

Individual, Breakout groups

Instructions:

1. **Explain** that participants will use the same breakout groups and the same scenarios for the previous activity (Shonda, Charles, Rainbow, Gonzalo).
2. Using **Handout #4**, they have 7 minutes to:
    a. Refresh their memory of the case scenario and
    b. Individually, identify which SUD assessments to use and why.
    c. Individually, consider what interventions may fit the client best and why.
3. They have 10 minutes, as a group, to come up with your combinations of what the group thinks would work for assessments and interventions.
4. Identify a spokesperson to report back.

After 17-20 minutes, **debrief** the activity by asking each group for just one assessment (and why) and just one intervention (and why).

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.

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

Wrap-Up and Evaluations

Time: **15 minutes**

Associated Objectives**: N/A**

Purpose: **Review the content covered and allow participants apply the learning objectives to current casework practice.**

Slide #58: P-I-E

Activity #6: P-I-E (7 minutes total)

Individual, Large Group

Instructions for Participants: Based on what we have talked about during our time together, I want you to answer a few questions.

1. P – Priceless piece of information. What has been the most important piece of information to you today?
2. I – Item to implement. What is something you intend to implement from our time today?
3. E – Encouragement I received. What is something that I am already doing that I was encouraged to keep on doing?

You have five minutes to answer the questions on your own.

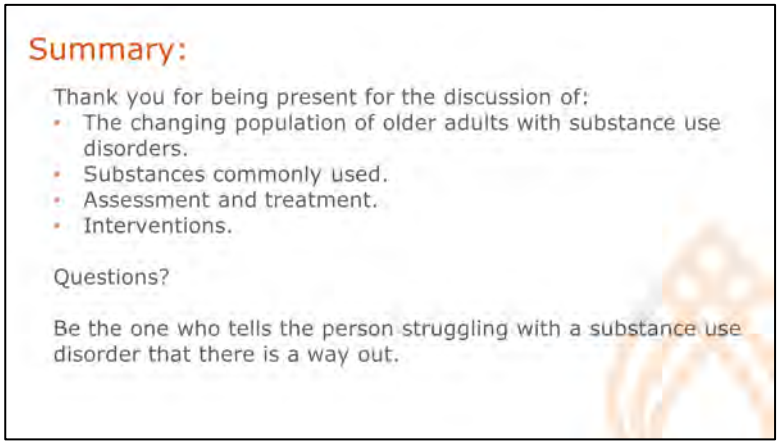
Once complete, **ask** for volunteers to share what they wrote down.

Use the following questions for debrief:

- What were some of the key words that you heard while you shared?
- What were the common themes that kept coming up?
- What would it mean for APS if we implemented the things on your PIE?

What would it mean for APS if we did not implement the things on your PIE

Slide #59: Summary



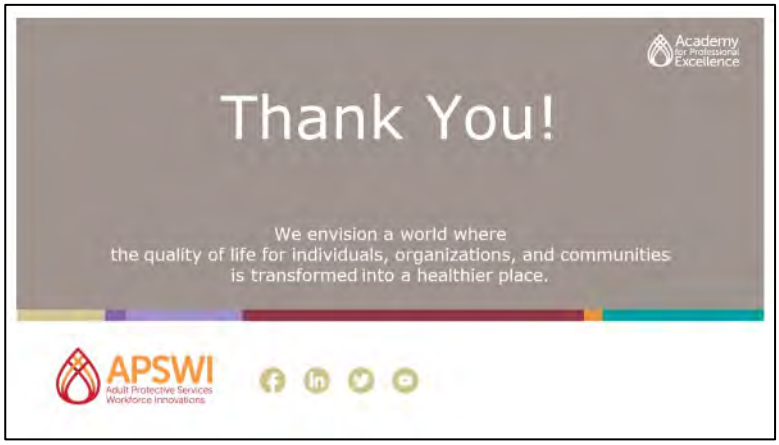
Explain:

- The point to this training has been to provide you, or increase, your foundational understanding of older adults and substance use. We also want to provide you with tools to place in your toolbox as you work with the growing population of older adults that have substance use issues.
- Hopefully it added to your knowledge and rounded out the big picture of substance use in older adults; their differences from other populations that struggle with substance use disorders, how the generation known as baby boomers will change the landscape, and how to provide this group the tools to live a life of recovery, whatever that looks like to them.

Ask if there are questions on the content covered?

To have a substance use disorder is to be in the tight grip of something that feels impossible to escape. Be the messenger that tells the person, “There is an escape, and there is a better life—but it will take some work”.

Slide #60: Thank you and Evaluations



Thank participants for being present and active in today's workshop and for the work they do every day.

Provide instructions on evaluations.

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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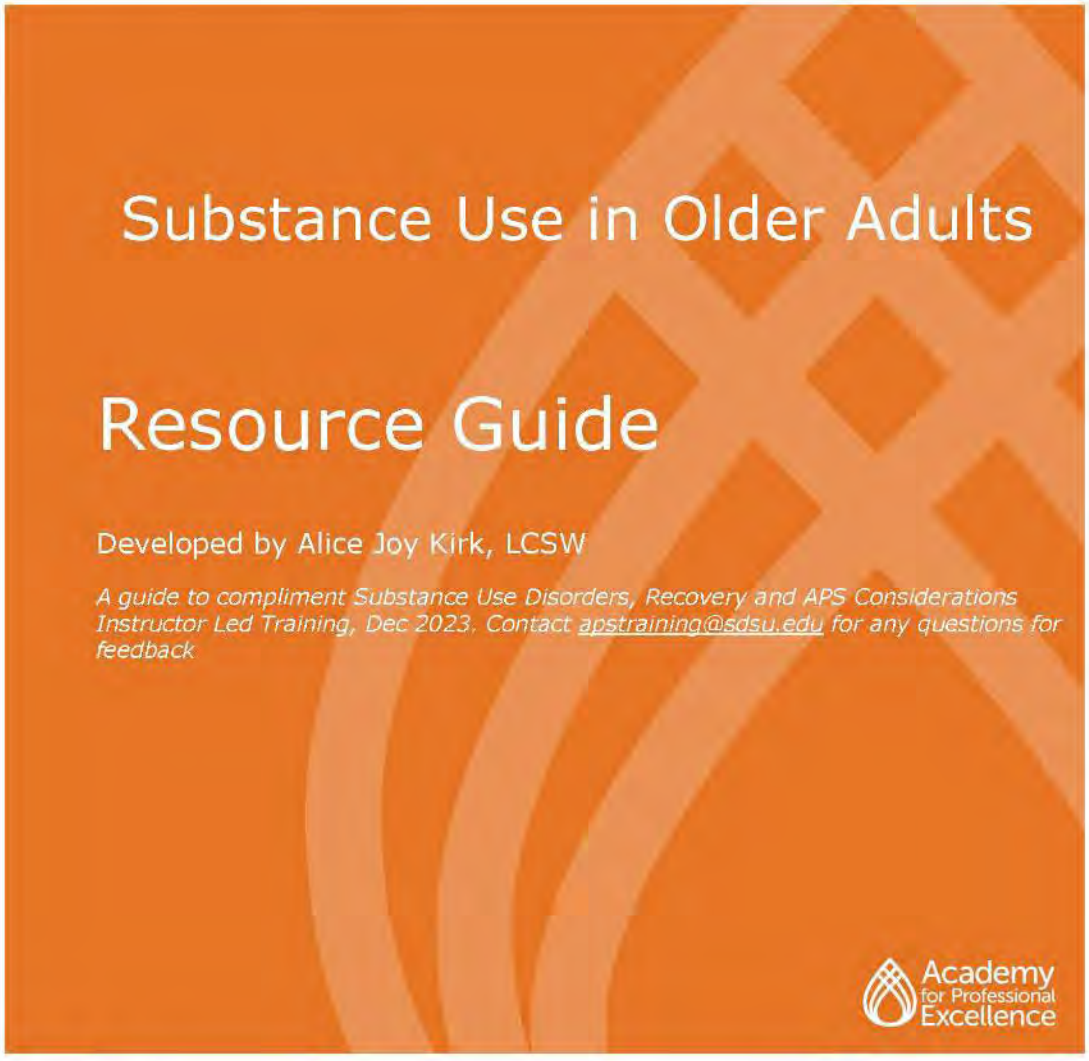
Appendix



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.

- 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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