WELCOME!

“Why does Grandma fall so much?”

Substance Misuse and Older Adults: Screening, Prevention and Treatment

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Support Together for Emotional and Mental Serenity & Sobriety
“Why Does Grandma Fall So Much?

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Consultation in recovery from substance use and mental disorders

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DRUG-FREE AMERICA

AGE 0-4  AMOXICILLIN  4-12  RITALIN  12-18  APPETITE SUPPRESSANTS  18-24  NO-DOZ  24-38  PROZAC  38-65  ZANTAC  65—EVERYTHING ELSE

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Prevalence Rates – Ages 65+

- Alcohol problems among older adults:
  - 2%-10% of community-based
  - 6% to 11% of hospital admissions
  - 14% in Emergency Departments
- Tobacco: About 10% are current users (similar rates for older men and older women)
- Prescription Drugs
  - 17% of hospitalizations of older adults are related to an adverse drug reaction – a rate 6 times greater than for entire population.
- OTC Products: Adults ages 65+ consume more OTC medications than any other age group.
- Illicit drug use – Low rate, but increasing trend?
12% of 55+ age group are either binge or heavy alcohol users.
What does the research tell us about older adults and substance abuse treatment?
Substance Abuse Treatment Program
Admissions Age 55 or Older
by Primary Substance at Admission
(DASIS Report December 2001)

**Primary substances in 1999:**

<table>
<thead>
<tr>
<th>Substance</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
<td>76.1%</td>
</tr>
<tr>
<td>Opiates</td>
<td>12.6%</td>
</tr>
<tr>
<td>Cocaine</td>
<td>4.5%</td>
</tr>
<tr>
<td>Marijuana</td>
<td>1.3%</td>
</tr>
<tr>
<td>Sedatives/Tranquilizers</td>
<td>0.7%</td>
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<tr>
<td>Stimulants</td>
<td>0.6%</td>
</tr>
<tr>
<td>Other</td>
<td>4.1%</td>
</tr>
</tbody>
</table>

Source: 1999 Treatment Episode Data System (TEDS)
Expert panel recommendations for screening and treating the older adult:

SAMHSA/CSAT Treatment Improvement Protocol (TIP) #26
TIP#26 Expert Panel Recommendations

1. Age-specific, group treatment that is supportive, not confrontive.
2. Attend to depression, loneliness; address losses.
3. Teach skills to rebuild social support network
4. Employ staff experienced in working with elders
5. Link with aging, medical, institutional settings
6. Content should be age-appropriate and offered at a slower pace.
7. Create a “culture of respect” for older clients
8. Broad, holistic approach recognizing age-specific psychological, social & health aspects.
9. Adapt treatment as needed to address gender issues
NIAAA (1995) recommended for individuals over the age of 65, "no more than one drink per day"

TIP#26 refinement:
• Maximum of 2 drinks on any drinking occasion (New Year's Eve, weddings)
• Somewhat lower limits for women.

Just a couple of beers ...
Screening & Brief Intervention

• What is the best way to identify older adults with alcohol or other substance use problems?
• What are alternatives to traditional substance abuse treatment?
• Focusing on primary care practice patients…
Screening Instruments that have been used with older primary care patients

- **S-MAST-G**: Short-Michigan Alcoholism Screening Test- Geriatric Version (10 items; Yes/No format)
- **AUDIT**: Alcohol Use Disorders Identification Test – Recommended for screening in ethnic minorities.
- **CAGE**: 4 item scale – CAGE may lack specificity (too many false positives). Should be enhanced with questions on Quantity/Frequency of alcohol use.
Short - Michigan Alcoholism Screening Test - Geriatric Version (SMAST-G)

- A 10 item screen
- Includes risk factors appropriate to elders
- YES/NO response format
- Scoring: 2 or more "YES" responses are indicative of an alcohol problem.

Source: Frederic C. Blow, Ph.D., University of Michigan Alcohol Research Center, Ann Arbor, MI
1. When talking with others, do you ever underestimate how much you actually drink?
2. After a few drinks, have you sometimes not eaten or been able to skip a meal because you didn't feel hungry?
3. Does having a few drinks help decrease your shakiness or tremors?
4. Does alcohol sometimes make it hard for you to remember parts of the day or night?
5. Do you usually take a drink to relax or calm your nerves?
6. Do you drink to take your mind off your problems?
7. Have you ever increased your drinking after experiencing a loss in your life?
8. Has a doctor or nurse ever said they were worried or concerned about your drinking?
9. Have you ever made rules to manage your drinking?
10. When you feel lonely, does having a drink help?
CAGE

1. Have you ever felt you should **Cut** down on your drinking?
2. Have people **Annoyed** you by criticizing your drinking?
3. Have you ever felt bad or **Guilty** about your drinking?
4. Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover (**Eye opener**)?

Scoring: Score 0 for "no" and 1 for "yes" answers. Higher scores indicate alcohol problems. A total score of 2 or greater is considered clinically significant. (Ewing, 1984).
Project GOAL: Brief Advice - Method
(Fleming et al. 1999)

- In Brief Intervention, the physician:
  - States his/her concern
  - Provides specific feedback to patients on how their drinking is affecting them (e.g., elevated blood pressure, liver function problems, family problems).
  - Gives a clear recommendation about changing their alcohol use.
  - Negotiates a drinking contract.
  - Provides a self-help (Health Promotion) booklet
  - Establishes follow-up procedures.

- Brief Intervention = 2 physician-delivered 15-min face-to-face visits (one month apart)
- Follow-up: by a nurse via telephone at 2 weeks, 3, 6, and 12 months.
Project GOAL: Results
(Fleming et al. 1999)

- Results:
  - 34% reduction in seven-day alcohol use.
  - 74% reduction in mean number of binge drinking episodes.
  - 62% reduction in percentage of older adults who had consumed more than 20 drinks per week at the beginning.

- Further research extended follow-up to two years, also with positive outcomes.
Extending Brief Interventions Beyond the Physician’s Office
Treating Older Adults with Alcohol Problems

- Outcomes are generally better than younger adults
- Late-onset may have the best outcomes
- Early studies involving group treatment have demonstrated several important points:
  - Depression, boredom and loneliness are frequent triggers to drinking
  - Those entering treatment often consume greater quantities than one might expect.
MEDICARE COVERAGE FACTORS TO CONSIDER

• **What kind of Medicare do you have?** Before seeking treatment, it is important that you understand what coverage you receive. You can check your enrollment. Most users are covered by Original Medicare, but some are covered by Medicare Advantage, a type of private health plan.

• **Do you have Medigap and what will it cover?** Medigap is supplemental insurance sold through a private company that covers the gaps in coverage that exist with Medicare. Medicare Matters explains these coverage gaps and how Medigap works.

• **Do you need inpatient or outpatient treatment?** Your plan will cover both inpatient and outpatient addiction treatment. Inpatient treatment is covered by Part A and outpatient treatment is covered by Part B up to 80 percent.

• **Do you meet the criteria for coverage?**
  - The treatment facility must participate in Medicare.
  - Your doctor must indicate that it is “medically necessary” and create a treatment plan.
  - Medicare must agree that the it is reasonable and necessary.

• **How do you find a facility that accepts Medicare?** The Substance Abuse and Mental Health Services Administration provides a Treatment Services Locator. Type in your City, State or zipcode to see a map of the facilities in your area.
Ageism
The term *ageism* was coined in the mid-1960s (Butler, 1969) to describe the tendency of society to assign negative stereotypes to older adults and to explain away their problems as a function of being old rather than looking for specific medical, social, or psychological causes. In American culture, ageism reflects a personal revulsion about growing old, comprising in part fear of powerlessness, uselessness, and death. Older adults often internalize such stereotypes and thus are less likely to seek out mental health and substance abuse care (Patterson and Dupree, 1994). Ageism may result in an older adult being classified as "senile," when in reality he or she may be afflicted with specific and sometimes treatable comorbid conditions such as Alzheimer's disease, depression, multi-infarct dementia, and alcoholism.
Other barriers to treatment in the older population:

- **Transportation**: (may be available to go to a hospital but not to AA or aftercare or evening programs): This is especially problematic in rural communities that lack public transportation or in poor urban communities where accessing transportation can be dangerous (Fortney et al., 1995).

- **Shrinking social support network**: Fewer friends to support them, participate in the treatment process, or take them places.

- **Time**: Despite the assumption that older adults have an excess of free time, they may well have to provide 24-hour supervision to a spouse, other relative, or friend, or have to care for grandchildren while the parent works.

- **Lack of expertise**: Few programs have specialists in geriatrics, treat many older adults, or are designed to accommodate functional disabilities such as hearing loss or ambulation problems.

- **Financial**: The structure of insurance policies can be a barrier to treatment. The carving out of mental health services from physical health services under managed care in particular can prevent older adults from receiving inpatient substance abuse treatment.
Health Profiles Project (Michigan)

- Largest randomized trial of brief alcohol advice to at-risk drinkers 60+ in primary care settings.
- 14,060 patients screened
- 454 entered randomized trial
- Outcome: *(preliminary results)*
  - Over 12 months: 30% decrease in experimental group and 20% decrease in control group alcohol consumption
In-Home Brief Intervention for older primary care patients with alcohol problems

- Staying Healthy Project (Cullinane, Blow, Barry, et al. – in progress)
  - Screened 4,300+ older adults in California
  - 166 people entered randomized trials
  - 39% decrease in Experimental
  - 28% decrease in Control

- Decline in drinking in both groups suggests that bringing attention to drinking may result in decrease.
Florida's Road To The BRITE Project

[Cartoon showing a road with signs saying 'Been There' and 'Done That']
Elderly Patients at Risk for Addiction

- The patient is a 71-year-old widowed man who is seen regularly in clinic for health maintenance and follow-up of his chronic insomnia and anxiety.
- He has regular prescriptions for triazolam (Halcion) and clonazepam (Klonopin) for these problems.
- Recently he has been reporting frequent episodes of losing his balance and falling, and eight weeks ago was hospitalized for a hip fracture sustained during one of these falls resulting in hip surgery. On this visit he also complains of becoming increasingly confused.

Possible Risk Factors?

- Age
- Widower - Social isolation?
- Medications?
- Insomnia
- Anxiety
- Falls
- Altered level of consciousness

Where do you go next?
Elderly Patients at Risk for Addiction

68 year-old woman presents to her primary care physician of 1 year with objective painful conditions (inflammatory arthritis, severe osteoarthritis, knee replacement, and a hip fracture associated with chronic prednisone use). She requests continued opioid therapy for these conditions. While this patient has been under her PCP’s care, the physician has received concerning information regarding her use of alcohol; a Driving Under the Influence charge, spousal complaints about her drinking, and a discharge summary from the emergency department visit related to injuries sustained after a fall from “mixing her pills with her drinks.”

Possible Risk Factors?
- Age
- Chronic pain syndrome
- Pain medications?
- Alcohol use
- Relationship problems
- Falls

Where do you go next?
Elderly Patients at Risk for Addiction

Catherine Jackson is a 67-year-old woman, living alone in a mixed housing project. For the past month, she has received visiting nurse services from your agency. These services were assigned to her upon discharge from the hospital with a diagnosis of anemia and uncontrolled adult-onset diabetes. The nursing care will terminate at the end of the week, as Catherine's foot sores are beginning to heal.

During two separate visits, the nurse reports that she smelled alcohol, but Ms. Jackson did not appear to be intoxicated. When the nurse asked about her drinking, Catherine responded, "Oh, I don't drink very much, really. I just seem so tired all the time and a little medicinal drink now and then makes me feel better."

Possible Risk Factors?

- Age
- Social isolation
- Medically fragile
- Alcohol use vs diabetic ketosis?
- Tolerance?
- Fatigue

Where do you go next?
Elderly Patients at Risk for Addiction

Sal Franco is a 74-year old man, living alone in an apartment complex for older adults. Sal and his wife, Maria, owned and operated a small, local grocery for 44 years. They sold the business to their son Dominic when Sal turned 70. The plan was to enjoy travel and retired life together. However, shortly after retiring, Maria was diagnosed with an aggressive leukemia, and she died within 4 months. Mr. Franco has been living alone for over 3 years. Because Sal and Maria spent most of their time working and involved with family activities, there are few close friends in his life. Dominic's family has Sal to dinner every Sunday, but has little time during the week because of competing demands. Sal's other children include a daughter living in another state who calls daily (but seldom visits because of the cost), a daughter overseas in military service, and a son with Down's Syndrome who lives in a group home about an hour away.
Elderly Patients at Risk for Addiction

Sal indicates that he was a "hard drinker" during his 20s and 30s, when he developed stomach problems and high blood pressure. At that point, he limited his use of alcohol to his Friday night poker club and to Sunday dinner with the family. Since Maria's death, Sal has regularly consumed 3 to 4 drinks a day. He says it alleviates some of the pain, stress, and loneliness. It also helps him sleep, along with the over-the-counter medications that he takes for arthritis pain and as sleep aides. He came to the clinic because his hypertension and gastritis have become extremely labile and intractable. When you ask Mr. Franco how he is doing, he says, "Oh, I guess I'm okay for an old widower. I don't think it really matters how I feel or what I do anymore at my age."

Possible Risk Factors?
Chronic Pain Syndrome

• Throughout the world, 1 in 5 people suffer from moderate to severe chronic pain.

• Chronic pain can have a significant negative impact on those afflicted, with effects including sleeplessness, decreased activity, and mood changes such as depression.

• The nerves in the periphery send pain signals through the dorsal root ganglia to the spinal cord and central nervous system, or CNS.

• In acute pain, nociceptors – pain receptors in peripheral nerves – are activated when the body experiences injury or inflammation. When pain is acute, signaling typically stops once the cause of pain is resolved.
Chronic Pain Syndrome

• However, when pain is chronic—lasting more than 3 months—repeated stimulation of these sensory nerves over time causes changes to the ways the pain signals are processed, leading to a pathophysiological state where the nervous system is sensitized and the perception of pain becomes heightened.

• These sensitized nociceptors then send additional pain signals to the CNS, which can lead to the overstimulation of the CNS, or central sensitization, which increases the perception of pain. As such, central sensitization leads to the perpetuation of pain.
Symptoms of the Chronic Pain Syndrome

- Perception of pain
- Reduced range of motion
- Reduced activity
- Muscular atrophy
- Increased inflammation
- Heightened perception of pain, etc. etc.
- Clinical depression
- Anxiety
- Avoidance behavior
- Pain catastrophizing
- Anger – irritability
- Social isolation
- Restricted activity
- Learned helplessness
THE LAB WHERE THEY STUDY DRUG INTERACTION
As You Age…
A Guide to
Aging, Medicines,
and Alcohol

Medicine and alcohol misuse can happen unintentionally.
Definitions of Proper Use, Misuse, Abuse, and Dependence

DSM-IV has defined the continuum of use of psychoactive prescription medications as follows:

- **Proper use**—Taking only medications that have been prescribed, for the reasons the medications are prescribed, in the correct dosage, and for the correct duration
- **Misuse (by patient)**
  - Dose level more than prescribed
  - Longer duration than prescribed
  - Use for purposes other than prescribed
  - Use in conjunction with other medications or alcohol
  - Skipping doses/hoarding drug
- **Misuse (by practitioner)**
  - Prescription for inappropriate indication
  - Prescription for unnecessary high dose
  - Failure to monitor or fully explain appropriate use
- **Abuse (by patient)**
  - Use resulting in declining physical or social function
  - Use in risky situations (hazardous use)
  - Continued use despite adverse social or personal consequences
- **Dependence**
  - Use resulting in tolerance or withdrawal symptoms
  - Unsuccessful attempts to stop or control use
  - Preoccupation with attaining or using the drug

Misuse and abuse are distinct from medication mismanagement problems, such as forgetting to take medications, and confusion or lack of understanding about proper use. Medication mismanagement problems can also have serious consequences for older adults, but they have different risk factors and typically require different types of interventions.

Who is at Risk for Psychoactive Prescription Medication Misuse and Abuse?

A number of factors have been associated with an increased risk of psychoactive prescription medication misuse/abuse among older adults:

- Female gender
- Social isolation
- History of substance abuse
- A mental health disorder, particularly depression

Older women are at higher risk because they are more likely to use psychoactive medications, especially benzodiazepines. This use may be associated with divorce, widowhood, lower income, poorer health status, depression, and/or anxiety.
Key Actions for Older Adults and Caregivers

- Carefully follow the directions for medication use; use the correct dose and only for as long as prescribed; ask about possible side effects and when to report these effects; read all medication-related information provided by doctors and pharmacists before starting a new medication.
- Inform doctors and pharmacists about all medications, including all OTC medications, that are being taken as well as alcohol use.
- Never use another person’s prescription medication.
- Inform the doctor if you believe a medication is not working. This is particularly important for pain management; older adults may take opioid analgesic medication in greater doses than prescribed if they are not getting adequate pain relief, which can potentially lead to misuse and abuse. Other medications or non-pharmaceutical approaches may be more appropriate before opioid analgesic doses are increased.

Key Actions for the Aging Services Network

- Integrate screening and brief interventions into existing programs, such as medication reviews.
- Implement depression and pain management programs, such as Healthy IDEAS, PEARLS, and the Chronic Pain Self-Management Program, to address common problems among older adults that can lead to psychoactive prescription medication misuse.
- Become familiar with and build relationships with substance abuse prevention and treatment providers in your community for cross-referrals and collaborative programs.

Key Actions for the Behavioral Health Network

- Learn about the unique aspects of serving older adults with substance misuse/abuse problems.
- Screen for and intervene as appropriate for older adults at risk for psychoactive prescription medication misuse and abuse.

Key Actions for Health Care Providers

- Integrate routine screening for medication and alcohol misuse into regular medical visits with older patients. Ask about substance abuse history; current alcohol, prescription, and OTC use; and reasons for use. Provide brief interventions/counseling for those who screen positive. Medicare reimburses physicians in primary care settings for screening and behavioral health counseling to reduce alcohol misuse. For more information, see Decision Memo for Screening and Behavioral Counseling Interventions in Primary Care to Reduce Alcohol Misuse.
- Note rapid increases in amount of psychoactive medication needed or frequent, unscheduled refill requests; intervene with older adults making these requests.
- Use caution when prescribing medications. Close follow-up will lead to successful treatment and management of pain, anxiety, and insomnia in older adults:
  - Monitor response to opioid analgesic medications and recommend non-pharmacologic approaches for pain management.\(^{17}\)
  - For anxiety, prescribe only short-acting benzodiazepines if needed at the lowest effective dose.
  - For insomnia, recommend behavioral therapy initially such as sleep hygiene and relaxation therapy. Consider the non-benzodiazepine sedative-hypnotics (zolpidem/Ambien\(^*\), eszopiclone/Lunesta\(^*\)), melatonin agonists (remerlon/ Rozerem\(^*\)), or intermediate-acting benzodiazepine at lowest effective dose for short-term use (no more than 3–4 weeks).\(^{18}\)
Resources

- **SAMHSA Guide to Preventing Older Adult Alcohol and Psychoactive Medication Misuse/Abuse: Screening and Brief Interventions**—This guide is designed to be used by a variety of health care and social service organizations interested in implementing an early intervention program focused on older adults who are at risk for alcohol and/or psychoactive prescription medication misuse or abuse. Available fall 2012.

- **SAMHSA Get Connected Tool Kit: Linking Older Adults with Medication, Alcohol, and Mental Health Resources**—This kit provides health and social services providers in the aging services field with health promotion and health education activities to prevent substance abuse and mental health problems in older adults. [http://www.samhsa.gov/Aging/age_10.aspx](http://www.samhsa.gov/Aging/age_10.aspx)

- **National Institute on Drug Abuse Research Report Series: Prescription Drug Abuse and Addiction**—This publication attempts to increase awareness about and promote additional research on prescription drug abuse. [http://www.drugabuse.gov/sites/default/files/rrprescription.pdf](http://www.drugabuse.gov/sites/default/files/rrprescription.pdf)

- **Substance Abuse Among Older Adults: A Guide for Social Service Providers**—This concise desk reference gives social service providers an overview of alcohol, prescription medication, and OTC drug abuse by older adults. [http://store.samhsa.gov/product/Substance-Abuse-Among-Older-Adults-For-Social-Service-Providers/SMA04-3971](http://store.samhsa.gov/product/Substance-Abuse-Among-Older-Adults-For-Social-Service-Providers/SMA04-3971)

- **Prescription and Illicit Drug Abuse**—This new topic on NIHSeniorHealth, explains why older people may abuse medications and illicit drugs and describes the possible effects of substance abuse on their health. Tips on how to prevent, recognize, and treat substance abuse in older adults are also included. [http://nihseniorhealth.gov/drugabuse/improperuse/01.html](http://nihseniorhealth.gov/drugabuse/improperuse/01.html)
Here are some signals that may indicate an alcohol or medication-related problem:

- Memory trouble after having a drink or taking medicine
- Loss of coordination (walking unsteadily, frequent falls)
- Changes in sleeping habits
- Unexplained bruises
- Being unsure of yourself
- Irritability, sadness, depression
- Unexplained chronic pain
- Changes in eating habits
- Wanting to stay alone a lot of the time
- Failing to bathe or keep clean
- Having trouble finishing sentences
- Having trouble concentrating
- Difficulty staying in touch with family or friends
- Lack of interest in usual activities
Medication Misuse – “Brown Bag” Review

Interviewer's impressions of the person after completing the "Brown Bag Review" of prescriptions:

1. Does not correctly recall the purpose of one or more medications
2. Reports the wrong dose/amount of one or more medications
3. Takes one or more medications for the wrong reasons or symptoms
4. Needs education and/or assistance on proper medication use
Medication Use: Client Interview Items

- Takes more than one type of prescribed medication
- Difficulty remembering how many meds to take
- Prescriptions from two or more doctors
- Felt worse soon after taking meds
- Taking meds to help sleep
- Uses up meds too fast
- Takes meds for nervousness or anxiety
- Doctor/nurse expressed concern about use of meds
- Take pain relieving meds
- Take pills to deal with loneliness, sadness
- Saving old medications for future use
- Chooses between cost of meds and other necessities
- A family member reminds them to take pills
- Uses dispenser or other method to help remind
- Fails to take meds supposed to
- Borrow someone else’s meds
- Feel groggy after taking certain medications
Doc? Can you write me a prescription for some of that Viagra?
OTC Medication Use – Client Interview Items

1. Do you frequently take aspirin, Tylenol, Advil, or other non-prescription pills for pain?
2. Do you ever tell your physician about the type of non-prescription pills you buy?
3. Do you use herbal pills such as Ginkgo, Saw Palmetto, St. John's Wort?
4. Do you take non-prescription pills or remedies for improving your memory?
5. Have you ever felt worse soon after taking over-the-counter remedies?
6. Are you taking medications to help you sleep?
7. Do any of the non-prescription pills you take make you feel groggy?
8. Do you use plants or herbs to make your own remedies such as garlic, or aloe?
The need to screen for illicit drug use.

An increasing trend among older adults?
Drug Use

Use of any of the following in past year:

1. Marijuana?
2. Cocaine?
3. Crack?
4. Heroin?
5. Hallucinogens (such as LSD, PCP)?
6. Substances - sniffed or inhaled?

Recorded by interviewer - YES/NO format. Any YES responses result in a Flag for further assessment.
Short - Geriatric Depression Scale

1. Are you basically satisfied with your life?
2. Have you dropped many of your activities and interests?
3. Do you feel that your life is empty?
4. Do you often get bored?
5. Are you in good spirits most of the time?
6. Are you afraid that something bad is going to happen to you?
7. Do you feel happy most of the time?
8. Do you often feel helpless?
9. Do you prefer to stay at home, rather than going out and doing new things?
10. Do you feel you have more problems with memory than most?
11. Do you think it is wonderful to be alive now?
12. Do you feel pretty worthless the way you are now?
13. Do you feel full of energy?
14. Do you feel that your situation is hopeless?
15. Do you think that most people are better off than you are?

Scoring:
5-9 = mild to moderate depression
10+ = serious levels of depression
Suicide Risk Items *

1. Has anyone in your family ever committed suicide?
2. If yes, who in your family committed suicide?
3. Have you ever thought about taking your life?
4. How recently have you thought about killing yourself?
5. Do you have a plan for doing this? (response selected from list of plans provided)
6. Have you ever been in the care of psychiatrist, psychologist, or other professional because of severe depression or mental problems?
7. Do you keep firearms in the house?
8. If yes, ask how many guns are in the house?

Brief Interventions can be delivered where older adults can be found

- In the elder’s home
- Senior center, congregate meal sites
- Home Health Care
- Physician’s office
- ER’s or Hospital rooms
- Workplace
- Even within the Substance Abuse Treatment Program!
Brief Treatment
A 16-session curriculum manual for conducting brief treatment
Dupree & Schonfeld (CSAT, 2005)
A Three Stage CBT/Self-Management Treatment Approach (Dupree & Schonfeld, CSAT 2005)

1. For each person in treatment, begin by conducting an analysis of the antecedents and consequences for substance use to create an individualized “substance use behavior chain” - Substance Abuse Profile for the Elderly

2. Teach the person how to identify the components of that chain so that he or she can understand the high risk situations for alcohol or drug use.

3. Teach specific skills to address these high risk situations to prevent relapse.

* Manual designed for group treatment. Includes complete word-for-word curriculum, exercises, assessments, homework assignments, and more.
### Self-Management Skills for Older Alcohol Abusers

<table>
<thead>
<tr>
<th>High Risk Situation</th>
<th>Skills Taught</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social Pressure</td>
<td>Drink Refusal</td>
</tr>
<tr>
<td>Loneliness</td>
<td>Rebuild Social Network</td>
</tr>
<tr>
<td>Depression</td>
<td>Cognitive Restructuring</td>
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<tr>
<td></td>
<td>Thought-stopping</td>
</tr>
<tr>
<td>Anxiety</td>
<td>Relaxation, Problem solving</td>
</tr>
<tr>
<td></td>
<td>Thought-stopping</td>
</tr>
<tr>
<td>Anger/Frustration</td>
<td>Assertiveness Training</td>
</tr>
<tr>
<td>Cues</td>
<td>How to dispose, avoid, rearrange</td>
</tr>
<tr>
<td>Urges</td>
<td>Thought-stopping, Learn to Delay</td>
</tr>
<tr>
<td>Slips</td>
<td>Relapse Training</td>
</tr>
</tbody>
</table>
Conclusions

• Screening older adults for substance misuse should focus on “at-risk” behaviors as well as more serious problems (involving dependence and tolerance)
• Screening should be addressed in:
  • Primary care
  • Aging services, senior centers, etc.
  • Health clinics
• Likely to see signs of depression associated with substance misuse
• Difficult to identify medication misuse, since it is a nebulous construct and requires review of patient characteristics and prescribing practices.
Beware...
The Baby Boomers are getting older!

A-A-R-P! I wanna join the A-A-R-P!

The Retirement Village People
Thank You for your interest and attention!

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Promoting dual recovery since 1984