

**CONDENSED CLINICAL PRACTICE GUIDELINE
TREATMENT OF CLIENTS WITH SUBSTANCE USE DISORDERS (SUD)**
Substance Abuse and Mental Health Services Administration. *Substance Abuse Among Older Adults: A Treatment Improvement Protocol (TIP) 26*

- I. Introductory remarks.
 - A. Until recently, alcohol and prescription drug misuse was not discussed in either the substance abuse or the gerontological literature.
 - B. Reasons for this silence are varied.
 1. Health care providers tend to overlook substance abuse among older people, mistaking the symptoms for those of dementia, depression or other problems common to older adults.
 2. Older adults are more likely to hide substance abuse and less likely to seek professional help.
 3. Many relatives of older adults with SUD are ashamed of the problem and choose not to address it.
 4. The TIP 26 predates the release of the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5)*. Therefore TIP 26 addresses suggested modifications to the criteria used to diagnose SUD in older adults in the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV)*. This condensed clinical practice guideline will focus on workable diagnostic models and recommendations from TIP 26 without elaborating on the DSM-V.
- II. Alcohol abuse.
 - A. Physiological changes, as well as changes in the kinds of responsibilities and activities pursued by older adults, make established criteria for classifying alcohol problems often inadequate for this population. The DSM-IV criteria for substance dependence include some that do not apply to many older adults and may lead to underidentification of drinking problems. TIP 26 recommends that clinicians consider the DSM-IV criteria for substance abuse and dependence may not be adequate to diagnose older adults with alcohol problems.
 - B. Some experts use the model of at-risk, heavy and problem drinking because it allows for more flexibility in characterizing drinking patterns.
 1. In this classification scheme, an *at-risk drinker* is one whose patterns of alcohol use, although not yet causing problems, may bring about adverse consequences, either to the drinker or to others
 2. The terms *heavy* and *problem* drinking signify more hazardous levels of consumption. Although the distinction between the terms *heavy* and *problem* is meaningful to alcohol treatment specialists interested in differentiating severity of problems among younger alcohol abusers, it is less relevant to older adults.
 3. To differentiate older drinkers, TIP 26 recommends using the terms at-risk and problem drinkers only.
 4. In this two-stage conceptualization, the *problem drinker* category includes those who would otherwise fall into the *heavy* and *problem* classifications

in the more traditional model as well as those who meet the DSM-IV criteria for abuse and dependence.

- C. TIP 26 recommends older men consume no more than one drink per day and a maximum of two drinks on any drinking occasion (e.g., New Year's Eve, weddings).
- D. TIP 26 recommends somewhat lower limits for women.

III. Abuse of prescription drugs.

A. Benzodiazepines.

1. Benzodiazepine use for longer than four months is not recommended for geriatric clients.
2. Among different benzodiazepines, longer-acting drugs such as flurazepam have long half-lives and are more likely to accumulate than the shorter acting ones. They are more likely to produce residual sedation; decreased attention, memory, cognitive function and motor coordination; and increased falls or motor vehicle crashes.
3. Some shorter-acting benzodiazepines such as oxazepam and lorazepam have simple metabolic pathways and are not as likely to produce toxic or dependence-inducing effects with chronic dosing.
4. Because of these side effects, TIP 26 recommends caution in selecting the most appropriate benzodiazepines for elderly clients

B. Sedatives/hypnotics.

1. Aging changes sleep architecture, decreasing the amount of time spent in the deeper levels of sleep and increasing the number and duration of awakenings during the night. However, these new sleep patterns do not appear to bother most medically healthy older adults who recognize and accept that their sleep will not be as sound or as regular as when they were young.
2. Although benzodiazepines and other sedatives/hypnotics can be useful for short-term amelioration of temporary sleep problems, no studies demonstrate their long-term effectiveness beyond 30 continuous nights, and tolerance and dependence develop rapidly.
3. TIP 26 recommends that symptomatic treatment of insomnia with medications be limited to seven to 10 days with frequent monitoring and reevaluation if the prescribed drug will be used for more than two to three weeks. Intermittent dosing at the smallest possible dose is preferred, and no more than a 30-day supply of hypnotics should be prescribed.
4. TIP 26 recommends clinicians teach older clients to practice good sleep hygiene rather than prescribe drugs in response to insomnia. The former includes regularizing bedtime, restricting daytime naps, using the bedroom only for sleep and sexual activity, avoiding alcohol and caffeine, reducing evening fluid intake and heavy meals, taking some medications in the morning, limiting exercise immediately before retiring, and substituting behavioral relaxation techniques.

C. Antihistamines.

1. Older persons appear to be more susceptible to adverse anticholinergic effects from antihistamines and are at increased risk for orthostatic hypotension and central nervous system depression or confusion.
2. Antihistamines and alcohol potentiate one another, further exacerbating the above conditions as well as any problems with balance. Because tolerance also develops within days or weeks, TIP 26 recommends that older persons who live alone do not take antihistamines.

IV. Identification, screening and assessment.

A. Screening.

1. TIP 26 recommends every 60-year-old be screened for alcohol and prescription drug abuse as part of his or her regular physical examination.
2. Problems can develop after screening has been conducted, and concurrent illnesses and other chronic conditions may mask abuse. No fixed rules govern the timing of screening. TIP 26 recommends screening or rescreening if certain physical symptoms are present or if older person is undergoing major life changes or transitions.
3. Standardized screening questionnaires are preferred. Other adults (e.g., visitors, volunteers, caretakers, health care providers) can also interject screening questions into normal conversations with older, homebound adults. Although the line of questioning will depend on the person's relationship with the older person and the responses given, TIP 26 recommends anyone concerned about an older adult's drinking practices try asking direct questions. Health care providers may preface questions about alcohol with a link to a medical condition when screening older people.
4. Although it is important to respect the older person's autonomy, in situations where a clear response is unlikely, participation from family/friends may be necessary.

B. Assessment instruments.

1. TIP 26 recommends use of the CAGE Questionnaire and the Michigan Alcohol Screening Test-Geriatric Version (MAST-G) to screen for alcohol use among older adults.
2. The Alcohol Use Disorders Identification Test (AUDIT) is recommended for identifying alcohol problems among older members of ethnic minority groups.
3. Substance abuse.
 - a. TIP 26 recommends a sequential approach that looks at various dimensions of an older adult's suspected problem in stages, so that unnecessary tests are not conducted.
 - b. TIP 26 recommends using two structured assessments with older adults: the substance abuse sections of the Structured Clinical Interview for DSM-III-R (SCID) and the Diagnostic Interview Schedule (DIS) for DSM-IV.
4. Functioning.

- a. To identify functional impairments, TIP 26 recommends measuring the activities of daily living (ADLs) and the instrumental activities of daily living (IADLs).
 - b. SF-36, a 36-item self-report questionnaire that measures health-related quality of life, includes both ADLs and IADLs.
5. Cognitive dysfunction.
 - a. Clients who have been medically detoxified should not be screened for cognitive dysfunction until several weeks after detoxification is completed, because a client not fully recovered from detoxification may exhibit some reversible cognitive impairment.
 - b. TIP 26 recommends use of the Orientation/Memory/Concentration Test, which can be completed in the office.
 - c. The Folstein Mini-Mental Status Exam (MMSE) is an acceptable alternative, although it can be insensitive to subtle cognitive impairments among older problem drinkers who have recently attained sobriety (past 30 – 60 days). The MMSE is weak on visual-spatial testing, which is likely to show some abnormality in many recent heavy drinkers.
 - d. The draw-a-clock task is a good task to complement the MMSE.
 - e. The Neurobehavioral Cognitive Status Examination, which includes screening tests of abstract thinking and visual memory (not measured on the MMSE), is also recommended for assessing mental status in this population.
 - f. The Confusion Assessment Method (CAM) is widely used as a brief, sensitive and reliable screening measure for detecting delirium. TIP 26 recommends a positive delirium screen be followed by careful clinical diagnostics based on established criteria and that any associated cognitive impairment be followed clinically using the MMSE.
6. Medical status.
 - a. TIP 26 recommends initial medical assessment of older adults include screening for visual and auditory problems, and any problems discovered be corrected as quickly as possible.
 - b. To assess the medication use of older adults, TIP 26 recommends the "brown bag approach." The practitioner asks the client to bring every medication they take in a brown paper bag, including over-the-counter and prescription medications, vitamins and herbs.
7. Sleep disorders.
 - a. TIP 26 recommends sleep history be recorded in a systematic way to both document the changes in sleep problems over time and to heighten the awareness of sleep hygiene.
8. Depression.
 - a. The Geriatric Depression Scale (GDS) and the Center for Epidemiological Studies Depression Scale (CES-D), have been validated in older age groups although not specifically in older adults with addiction problems. TIP 26 recommends the CES-D for

use in general outpatient settings as a screen for depression among older clients.

V. Treatment.

- A. TIP 26 recommends older substance abusers enter treatment with the least intensive treatment options explored first. These initial approaches can function either as pretreatment strategy or treatment itself. In order of priority, they are brief intervention, intervention and motivational counseling. They may be sufficient to address the problem; if not, they can help move a client toward specialized treatment.
- B. Conducting brief interventions.
 1. Brief intervention is one or more counseling sessions, which may include motivation for change strategies, client education, assessment and direct feedback, contracting and goal setting, behavioral modification techniques, and the use of written materials such as self-help manuals.
 2. Older adult-specific brief intervention should include the following steps.
 - a. Customized feedback on screening questions relating to drinking patterns and other health habits such as smoking and nutrition.
 - b. Discussion of types of drinkers in the United States and where the client's drinking patterns fit into the population norms for his or her age group.
 - c. Reasons for drinking. This is particularly important because the practitioner needs to understand the role of alcohol in the context of the older client's life, including coping with loss and loneliness..
 - d. Consequences of heavier drinking.
 - e. Reasons to cut down or quit drinking. Maintaining independence, physical health, financial security and mental capacity can be key motivators in this age group.
 - f. Sensible drinking limits and strategies for cutting down or quitting. Strategies that are useful in this age group include developing social opportunities that do not involve alcohol, getting reacquainted with hobbies and interests from earlier in life, and pursuing volunteer activities, if possible.
 - g. Drinking agreement in the form of a prescription. Agreed-upon drinking limits that are signed by the client and the practitioner are particularly effective in changing drinking patterns.
 - h. Coping with risky situations. Social isolation, boredom, and negative family interactions can present special problems in this age group.
 - i. Summary of the session.
- C. Intervention.
 1. Intervention is when several significant people in a substance-abusing client's life confront the client with their firsthand experiences of drinking or drug use.
 2. The formalized intervention process includes a progressive interaction by the counselor with the family or friends for at least two days before meeting with the older adult.

3. TIP 26 recommends the following modifications to interventions for older adults. No more than one or two relatives or close associates should be involved along with the health care provider; having too many people present may be emotionally overwhelming or confusing for the older person. Inclusion of grandchildren is discouraged.
- D. Motivational counseling (MC).
1. MC acknowledges differences in readiness and offers an approach for "meeting people where they are" that has proven effective with older adults. It is an intensive process that enlists clients in their own recovery by avoiding labels and confrontation, accepting ambivalence about the need to change as normal, inviting clients to consider alternative ways of solving problems, and placing responsibility for change on the client.
 2. A counselor listens and accepts the older adult's perspective on the situation as a starting point, helps to identify the negative consequences of substance abuse, helps the older adult to shift perceptions about impact of drinking or drug-taking habits, helps to generate insights about and solutions for the problem, and supports capacity for change.
- E. Detoxification.
1. Older adults should be withdrawn from alcohol or from prescription drugs in a hospital setting. Medical safety and removal from continuing access to alcohol/abused drugs are primary considerations in this decision..
 2. Indicators that inpatient hospital supervision is needed for withdrawal from a prescription drug include the following.
 - a. High potential for developing dangerous abstinence symptoms such as a seizure or delirium because the dosage of a benzodiazepine or barbiturate has been particularly high or prolonged and has been discontinued abruptly or because the client has experienced these serious symptoms at any time previously.
 - b. Suicidal ideation or threats.
 - c. Presence of other major psychopathology.
 - d. Unstable or uncontrolled comorbid medical conditions requiring 24-hour care or parenterally administered medications.
 - e. Mixed addictions, including alcohol.
 - f. Lack of social supports in the living situation or living alone with continued access to the abused drug.
 3. In general, TIP 26 recommends that initial dose of a drug for suppression and management of withdrawal symptoms should be one-third to one-half the usual adult dose, sustained for 24 – 48 hours to observe reactions, then gradually tapered with close attention to clinical responses.
- F. Treatment settings
1. TIP 26 recommends clients who are brittle, frail, acutely suicidal or medically unstable or who need constant one-on-one monitoring receive 24-hour primary medical/psychiatric/nursing inpatient care in medically managed and monitored intensive treatment settings.

2. As part of outpatient treatment, TIP 26 recommends the physician function as an active participant in the treatment planning process and in the recovery network.
 3. TIP 26 recommends serving older people dependent on psychoactive prescription drugs in flexible, community-oriented programs with case management services rather than in traditional, stand-alone substance abuse treatment facilities with standardized components.
- G. Treatment approaches.
1. TIP 26 recommends incorporating six features into treatment of older alcohol abusers:
 - a. Age-specific group treatment that is supportive and nonconfrontational.
 - b. Focus on coping with depression, loneliness and loss.
 - c. Focus on rebuilding the client's social support network.
 - d. A pace and content of treatment appropriate for older adults.
 - e. Linkages with case management, medical services, services for the aging and institutional settings.
 - f. Staff members who are interested and experienced in working with older adults.
 2. Building from these six features, TIP 26 recommends treatment programs adhere to the following principles.
 - a. Treat older people in age-specific settings where feasible.
 - b. Create a culture of respect for older clients.
 - c. Take a holistic approach to treatment that emphasizes age-specific psychological, social and health problems.
 - d. Keep the treatment program flexible.
 - e. Adapt treatment as needed in response to client's gender.
 - f. To help ensure optimal benefits for older adults, treatment plans should weave age-related factors into the contextual framework of the American Society of Addiction Medicine (ASAM) criteria.
 3. TIP 26 recommends the following general approaches for effective treatment of older adult substance abusers.
 - a. CBT approaches.
 - b. Group-based approaches.
 - c. Individual counseling.
 - d. Medical/psychiatric approaches.
 - e. Marital and family involvement/family therapy.
 - f. Case management/community-linked services and outreach.
 4. TIP 26 recommends CBT focus on teaching skills necessary for rebuilding the social support network; self-management approaches for overcoming depression, grief or loneliness; and general problem solving.
 5. With treatment groups, TIP 26 recommends older clients should get more than one opportunity to integrate and act on new information. To help participants integrate and understand material, it is helpful to expose them to all units of information twice.

6. Older people in educational groups can receive, integrate and recall information better if they are given a clear statement of the goal and purpose of the session and an outline of the content to be covered. TIP 26 recommends use of simultaneous visual and audible presentation of material, enlarged print, voice enhancers and blackboards or flip charts.
7. It is important to recognize clients' physical limitations, which will be reflected in the duration of group sessions and accommodation to sensory needs.
8. TIP 26 recommends counselors providing individual psychotherapy treat older clients in a nonthreatening, supportive manner.
9. Medications used to modify drinking behavior in older adults must take into account age- and disease-related increases in vulnerability to toxic drug side effects, as well as possible adverse interactions with other prescribed medications.
 - a. Disulfiram is not generally recommended by the TIP 26 for use in older clients because of the hazards of the alcohol-disulfiram interaction, as well as the toxicity of disulfiram itself.
 - b. Of the other pharmacotherapies for alcohol abuse, naltrexone is well tolerated by older adults and may reduce drinking relapses.
10. Depression for several days or longer immediately after a prolonged drinking episode does not necessarily indicate a true comorbid disorder or the need for antidepressant treatment in most cases. When depressive symptoms persist several weeks following cessation of drinking, antidepressant treatment is indicated.
11. Advantages of quitting smoking are clear, even in older adults. TIP 26 recommends efforts to reduce substance abuse among older adults also include help in tobacco smoking cessation..

H. Staffing considerations

1. TIP 26 recommends the following principles guide staffing choices in substance abuse treatment programs.
 - a. Employ staffs who have completed training in gerontology.
 - b. Employ staff who like working with older adults.
 - c. Provide training in empirically demonstrated principles effective with older adults to all staff who will interact with these clients.
2. TIP 26 members believe any program that treats even a few older adults should have at least one staff person who is trained in the specialization of gerontology within his or her discipline. This training should consist of at least a graduate certificate program in the subfield of aging commonly called social gerontology. Staff with professional degrees should have a specialization in gerontology, geriatrics or psychogeriatrics.

I. Outcomes and cost issues in alcohol treatment.

1. Outcome assessment is valuable from a management and referral perspective. The providers of treatment, the clinicians and referring agencies, and clients need to have information regarding the likely outcomes of treatment.

2. Because treatment options range from brief interventions to structured outpatient and inpatient treatment programs, the TIP 26 recommends evaluation of outcomes at varying points in the treatment process.
3. Baseline data should be obtained at the beginning of the intervention or treatment; first follow-up evaluations should be conducted two weeks to one month after the client leaves the inpatient setting. Outpatient outcomes should be assessed no sooner than three months and possibly as long as 12 months after treatment.
4. TIP 26 recommends outcome measurement include abstinence/reduced consumption; patterns of alcohol use; alcohol-related problems; physical and emotional health functioning; and quality of life.
5. TIP 26 recommends the Medical Outcomes Study 36-Item Short Form Health Survey (SF-36) for physical/mental health; the Symptom Checklist-90-Revised (SCL-90-R) and its abbreviated version, the Brief Symptom Inventory (BSI) as a measure of psychological distress useful for alcohol outcomes assessment with older adults; for measuring quality of life TIP 26 recommends the Quality of Life Interview (QLI).

References

American Psychiatric Association: *Practice guideline for the treatment of clients with substance use disorders*. 2nd Ed. Arlington (VA). (August 2006).

American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders - Fifth Edition (DSM-V)*. Arlington, VA: American Psychiatric Publishing, Inc.; 2013.

Mee-Lee, D., Shulman, G.D., Fishman, M., Gastfriend, D.R., Griffith, J.H. (eds): *ASAM Client Placement Criteria for the Treatment of Substance-Related Disorders*, 2nd ed., revised. Chevy Chase, MD: American Society of Addiction Medicine; 2001.

Substance Abuse and Mental Health Services Administration. *Substance Abuse Among Older Adults: A Treatment Improvement Protocol 26*. U.S. Department of Health and Human Services (October 2008).

VA/DoD Clinical Practice Guideline. *Management of Substance Use Disorders*. VA/DoD Evidence Based Practice. Veterans Health Administration/Department of Defense. Version 2.0 (2009).

Other Resources

The full VA/DoD SUD guideline can be accessed at www.healthquality.va.gov/ and www.qmo.amedd.army.mil/substance%20abuse/substance.htm

National Institute on Alcohol Abuse and Alcoholism (NIAAA)
[www.niaaa.nih.gov/Publications/
EducationTrainingMaterials/Pages/guide.aspx](http://www.niaaa.nih.gov/Publications/EducationTrainingMaterials/Pages/guide.aspx)

On the NIAAA website, providers can find resources including clinical guides and videos on alcohol screening and brief intervention, alcohol use disorder screening instruments and assessment support materials, medication wallet cards and client materials. For additional resources, visit www.RethinkingDrinking.niaaa.nih.gov.

National Institute on Drug Abuse (NIDA)
www.drugabuse.gov/nidamed/

NIDA provides resources including screening tools, charts of commonly abused drugs, drug abuse reports, multilingual education packets and client-physician conversation posters.

Substance Abuse and Mental Health Services Administration (SAMHSA)

www.dpt.samhsa.gov/providers/providerindex.aspx

SAMHSA provides resources for provider training on substance abuse, addiction, prescribing and risk management, as well as resources on addiction treatment forums, treatment protocols and drug interactions.

Medical and Non-Medical Addiction Specialists

American Academy of Addiction Psychiatry

(www.aaap.org) 1-401-524-3076

American Psychological Association

(<http://apa.org>) 1-800-964-2000

American Society of Addiction Medicine

(www.asam.org) 1-301-656-3920

The Association for Addiction Professionals

(www.naadac.org) 1-800-548-0497

National Association of Social Workers

(www.socialworkers.org or www.helpstartshere.org)

Alcoholics Anonymous

(www.aa.org) 1-212-870-3400 or check your local phone directory under “Alcoholism”

Secular Organizations for Sobriety

(www.cfiwest.org/sos/index.htm) 1-323-666-4295

Al-Anon/Alateen

(www.al-anon.alateen.org) 1-888-425-2666 for meetings

Adult Children of Alcoholics

(www.adultchildren.org) 1-310-534-1815

Veterans Crisis Line

(www.mentalhealth.va.gov/suicide_prevention/index.asp)

1-800-273-8255 and press 1

Substance Abuse Treatment Facility Locator

(www.findtreatment.samhsa.gov) 800-662-HELP (4357)

www.healthquality.va.gov/Substance_Use_Disorder_SUD.asp

