

Clinical Considerations for Substance Use Issues in Long-Term Care Facilities

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## **Introduction**

Substance use in older adults is receiving increased attention. As the Baby Boomer generation ages, there is concern that substance use will present novel issues to be addressed in long-term care facilities. Substance use issues have been well documented in this population and are unlikely to resolve solely due to aging. And although healthcare workers, including nurses, nursing aids, and other providers are well positioned to address these issues, they may lack knowledge for assessing and intervening in substance use and withdrawal from substance use. There is a need for continuing education on substance use issues and disorders in older adults.

## **Background and Importance**

Substance use (substance use disorders, binge drinking, substance misuse, substance abuse) is a growing problem in older adults. In 2018, over one million older adults (65 years or older) had a substance use disorder (Substance Abuse and Mental Health Services Administration [SAMHSA], 2019), and 29% to 49% of long-term care residents reported a lifetime diagnosis of a substance use disorder (Blow & Barry, 2014). Historically, research on substance use issues in older adults has focused on alcohol use disorder and alcohol use. However, prescription narcotics and illicit substance use are of increasing concern in this population (Sorrell, 2017). Substance use patterns and prevalence vary in adults over the age of 50 years, with a higher prevalence of substance use in younger older adults. Of 50- to 54-year-olds, 15.1% have reported illicit substance use and 1.2% have reported misuse of prescription opioids and benzodiazepines in the previous year, whereas individuals 65 years or older have reported 7.1% illicit substance use and 0.5% misuse of prescription opioids and benzodiazepines (SAMHSA, 2019). Similarly, alcohol use is common in older adults (49.1% of all adults 50 years or older), and past-month binge drinking and alcohol use are on the rise in older adults (Han et al. 2017). Younger older adults (50 to 54 years old) demonstrate higher rates of alcohol use than do individuals 65 years and older (56.1% vs. 43.9%, respectively), of binge drinking (25.7% vs. 10.7%), and of heavy drinking (7.7% vs 2.8%) (SAMHSA, 2019). First-time treatment for older adults with alcohol or opioid use disorder has increased significantly over the last decade (Huhn et al., 2019; Huhn et al., 2018), and hospitalizations for alcohol withdrawal in those 65 years or older increased from 2005 to 2014 (Kohli et al., 2020). The aging Baby Boomer generation has shown a high rate of substance use (Cross & Kleinhesselink, 1985), with an increasing awareness of substance use issues and subsequent treatment (U.S. Department of Health & Human Services, 2016).

Aging also places older individuals at risk for polypharmacy (Hales et al., 2019). Older adults are likely to visit multiple doctors to receive their care, which predisposes them to receive multiple medications and increases their risk for drug interactions and multiple prescriptions of controlled substances. Recent studies have found an increase in polypharmacy-related provider visits that included an opioid (Gerlach et al., 2017). Multiple chronic illnesses, functional impairments, and cognitive deficits resulting in polypharmacy place older adults at risk for drug-related harm. Medications for psychological or physical pain can result in re-emergence of previous substance use issues or the development of new ones (Lazar, 2016).

In addition to adverse medical outcomes, older adults are at risk for worsening mental health (Webster et al., 2016), which also predisposes them to developing problematic substance use (Han et al., 2017). At the same time, worsening mental health can be an indicator of substance use issues. These complexities make substance misuse, abuse, and substance use disorders challenging to treat in older adults.

The aging population includes those who are homeless. Those born in the latter half of the Baby Boom generation are more likely to experience homelessness than other age cohorts (Culhane et al., 2013). Over the last 20 years, the rate of homelessness in older adults has almost tripled, such that older adults represent approximately one third of all homeless individuals (Hahn et al., 2006). Nearly half of older adults have become homeless after reaching the age of 50 (R. T. Brown et al., 2016).

Homeless individuals have significantly higher rates of comorbid physical issues, psychiatric illness, and substance use disorders (Kushel, 2012). R. T. Brown et al. (2016) found that those who have become homeless before age 50 have a history of adverse life experiences including mental health problems, substance use, low socioeconomic status, and poor social support. Yet those with later onset homelessness are more likely to have unmet needs regarding substance use (Kaplan et al., 2019). It is thus more likely that they will be placed in long-term care facilities once they receive care, which commonly occurs as a result of emergency department visits. Even though a significant number of homeless older adults experience substance use issues, many do not receive adequate care for those issues (Kaplan et al., 2019). Healthcare providers need to be aware of these higher rates of prior substance use, which may have contributed to homelessness in the first place, and understand the resulting complications for management of comorbid diseases.

In older adults, significant barriers and unique population-specific complexities are related to substance use treatment: geographic isolation, cost, stigma, issues with diagnosis and identification of the problem, transportation, and physical accessibility. Although inpatient treatment for substance use disorders is on the rise, older adults are more likely to access treatment through outpatient or residential services (Huhn et al., 2018). Such treatment has limitations. Outpatient and residential services are less likely to offer medications for alcohol use disorder to older adults (Huhn et al., 2018), and substance use disorder treatment facilities for older adults are limited. In the U.S., fewer than 20% of substance use treatment programs offer options designed specifically for the older adult (Huhn et al., 2019; Sacco & Kuerbis, 2013). Older adults are more likely to have co-morbid medical conditions that increase the complexity of treating their substance use disorder. For example, over 50% of older adults in the U.S. report experiencing chronic or bothersome pain in the past month (Reid et al., 2015). Unfortunately, few facilities can handle this level of complexity, recognize the nuances of withdrawal, or properly counsel older adults about maintaining recovery once they leave treatment. The 1.3 million older adults living in long-term care facilities are more likely to have multi-morbidity (multiple chronic diseases, cognitive issues; Harris-Kojetin et al., 2019; Koller et al., 2014), placing them at particularly high risk for adverse events related to concomitant substance use issues.

## **Clinical Considerations**

### **Screening**

Long-term care facilities must use valid, reliable instruments to screen for current substance use disorders or possibly risky substance use. In a recent study on such facilities' policies and practices, White et al. (2015) found that fewer than half screened for substance abuse on admission. Use of the screening component of the Florida screening and intervention program BRITE (Schonfeld et al., 2010) or the CAGE-AID (R. L. Brown & Rounds, 1995; Hinkin et al., 2001) during intake assessment is a cost effective, brief, valid way to identify substance abuse issues early in the resident's stay in long-term care. Even when individuals are

in recovery and are abstaining from substance use, it is important to assess past use and issues with substance use, owing to high comorbidity with psychiatric disorders.

Another way to assess for substance use issues is to corroborate information with family. White et al. (2015) found that a majority of long-term care facilities reported talking to family or friends about the resident's possible substance use. Corroborating information with those closest to the resident is recommended. However, given the nature of addiction (which can include the resident's concealment of behaviors) and the stigma associated with it, initial screening with a validated tool is preferable.

In addition to screening, care providers—nurses, clinical assistants, and other providers—should be comfortable conducting a brief semistructured interview to explore substance use. The care provider should feel comfortable in asking about type of substance(s) used, quantity/amount of use, frequency of use, previous treatment, and recovery episodes. Healthcare providers may bristle at the idea of discussing these topics with their patients, which speaks to the significant stigma surrounding substance use patterns and behaviors. Clarifying substance use behaviors and patterns signals to the resident that this topic is not taboo, and it will help the care team identify whether any issue should be addressed. Additional questions to consider include the following: Have you ever taken an extra pill to fall asleep or cope with pain? Have you previously run out of medications early? Have you ever needed to borrow a family member's or friend's medication?

### **Signs and Symptoms of Substance Use Issues**

There are specific signs and symptoms of substance use disorders and withdrawal from substance use (see Table 1). A knowledge of these signs and symptoms can help staff identify substance use issues that are unreported at intake or that develop after the resident enters the long-term care facility. The *Diagnostic and Statistical Manual of Mental Disorders 5 (DSM-5)*; American Psychiatric Association, 2013) presents criteria for the diagnosis of substance use disorders (Table 2). There are 11 criteria, which fall into four categories: impaired control, social/functional impairment, risky use, and pharmacological tolerance or withdrawal. According to the *DSM-5*, the diagnosis of a substance use disorder must meet a minimum 2 of the 11 criteria, persisting over 12 months. If an individual meets a greater number of criteria, the diagnosis is further differentiated for severity: 2 and 3 indicate “mild”; 4 and 5, “moderate”; and 6 or more, “severe.” For psychiatric disorders, which include substance use disorders, increased severity corresponds to worsening outcomes and functioning (Adair et al., 2005; Birnbaum et al., 2010; Dixon, 1999).

Unique attributes in the older population can make it more challenging to accurately diagnose a substance use disorder (Kuerbis, 2020). Role responsibilities change throughout adulthood and into older adulthood. Those over 60 are more likely to be retired; in such instances, rather than asking about how substance use affects work, ask about how it affects their ability to care for their spouse or home (criterion 5). Also, activities and social activities in general may be reduced in older adults. This predisposes the resident and care provider to assume that such changes are a result of “normal” aging rather than a symptom of substance use (criterion 6; Kuerbis, 2020). Cognitive impairments caused by substance use may not be recognized as substance use issues but may be attributed simply to aging as well. Cognitive changes can mask substance use disorders, and substance use can exacerbate cognitive conditions (Sorrell, 2017). One way to discriminate a substance use disorder in older adults is to identify a history of unsuccessful efforts to reduce use, social and interpersonal problems (i.e., arguments with family or friends), and symptoms of withdrawal (Kuerbis, 2020).

In older adults, symptoms of withdrawal can be more “subtle and protracted” (Barry et al., 2002, p.109), likely due to physiological changes as individuals age with slowing of the metabolic process. Early stages of withdrawal can look like changes in mood (increased anxiety, increased depression) and the individual’s appearing physically unwell (sweating, nausea, chills, muscle soreness). These symptoms can be mistaken for other common illnesses such as a cold or food poisoning. Noting the onset and frequency of these symptoms can aid in identifying a problematic pattern of substance use. For example, if an individual develops symptoms such as sweating, nausea, and confusion 12–24 hr after admission, this might be due to discontinued use of alcohol or other substances. Moderate withdrawal can develop with dehydration, electrolyte imbalances, vomiting, and insomnia and can progress to severe withdrawal with seizures and cardiac ischemia. Behaviors related to withdrawal symptoms can include difficulty participating in facility activities or treatment plans, nonadherence to physical therapy or occupational therapy, and difficulty in self-care. Two scales used for the identification and rating of withdrawal symptoms include the Clinical Opiate Withdrawal Scale (COWS) for opioid (prescription medications, fentanyl, heroin, etc.) withdrawal and the Clinical Institute Withdrawal Assessment (CIWA) for alcohol withdrawal.

Anecdotally, many assume that withdrawal from opioids or methamphetamine is more severe, given the illicit nature of such substances. However, individuals are at highest risk for seizure and death when withdrawing from alcohol and benzodiazepines. In these instances, the resident should be referred to a medically monitored withdrawal facility or a hospital. Older adults are at increased risk for adverse events associated with all forms of substance withdrawal due to increased medical complexities and changes in metabolic function. During withdrawal from substance use, older adults require a high level of monitoring.

### **Medications for Substance Use Disorders**

If not addressed, substance use issues will continue to undermine treatment for comorbid psychiatric and medical illnesses. Therefore, substance use issues and disorders should be a priority in caring for older adults. In all instances of substance use disorders, the individual should be engaged in a “full-continuum of care” during early recovery, which may include residential care, partial hospitalization, and intensive outpatient hospitalization. During that time, they individual should receive care from providers who can continue to provide any medications started during treatment, as well as a support network of other individuals engaged in recovery.

In conjunction with psychosocial treatment and support, FDA-approved medications for certain substance use disorders can be used in treatment (medication-assisted treatment, or MAT). Because substance use disorders are now viewed less as acute illnesses that reflect a moral failing than as chronic illnesses that require long-term support, medications for substance use disorders have become more accepted (McLellan et al., 2000; SAMHSA, 2020a). Such treatment works best when combined with behavioral therapies and counseling (SAMHSA, 2020a).

FDA-approved medications for the treatment of opioid use disorder include methadone, buprenorphine, naltrexone, and Suboxone (naltrexone and buprenorphine combined). These medications act on opioid receptors by reducing cravings and/or blocking the euphoric effects of heroin and other opioids (Stahl, 2013). Methadone is a full opioid agonist; it acts on opioid receptors in the brain in the same way as do heroin and other opioids, except that it has a longer half-life. Methadone primarily occupies the  $\mu$ -opioid receptors, blocking the euphoric effects of other opioids (including heroin) in the brain (Alderks, 2013). Buprenorphine is a partial agonist at the  $\mu$ -opioid receptors and only partially activates the receptors; its high affinity for binding at

the  $\mu$ -opioid receptor and slow-dissociation kinetics block other full-opioid agonists from binding (SAMHSA, 2019). Naltrexone is an opioid receptor antagonist and has high affinity for the  $\mu$ -opioid receptors. Once bound, naltrexone blocks the euphoric and sedative effects of opioids (SAMHSA, 2019). Unlike methadone and buprenorphine, naltrexone does not activate the opioid receptors. Combination medications of buprenorphine and naltrexone (Bunavail, Suboxone, Zubsolv) have been created to decrease the abuse of buprenorphine.

Naloxone is also used in certain instances for those with an opioid use disorder. It is not considered a form of MAT. Rather, it is a rescue medication, used in instances of overdose. Naloxone is an opioid receptor antagonist with a high affinity for opioid receptors; it rapidly removes any other drugs or substances bound to those sites (Newman et al., 2000). Naloxone should be available for patients who are taking high doses of opioids, misusing an opioid prescription, or using illicit opioids. U.S. Surgeon General Jerome Adams (2018) has written that “health care practitioners, family and friends of people who have an opioid use disorder, and community members who come into contact with people at risk for opioid overdose, knowing how to use naloxone and keeping it within reach can save a life.” Forty-two states and the District of Columbia have active standing orders that make naloxone available without a prescription. Nurses working in long-term care facilities should advocate for the availability of this medication in their facilities. Educating residents, their families, and caregivers about the medication’s availability, especially when a resident is prescribed an opioid medication, could save a life in the case of an overdose.

There are also FDA-indicated medications for alcohol use disorder. These include disulfiram (Antabuse), acamprosate (Campral), and naltrexone. Disulfiram works by irreversibly inhibiting aldehyde dehydrogenase, the enzyme involved in second-stage metabolism of alcohol (Stahl, 2013, 2017). If an individual consumes alcohol while on this medication, a toxic level of acetaldehyde builds up and causes unpleasant side effects—flushing, headache, tachycardia, nausea, and vomiting. Disulfiram is used as a classic aversion therapy (American Psychiatric Association, 2018). On the other hand, acamprosate works by theoretically reducing excitatory glutamate and increases inhibitory gamma-aminobutyric acid (Stahl, 2013, 2017). This action results in decreased cravings for alcohol. A benefit to acamprosate is that it is not hepatically metabolized, so that it is a good choice for those with liver function issues. Naltrexone is also used to reduce alcohol cravings. However, it can have adverse effects on those with liver function issues, so liver function must be assessed prior to starting naltrexone (Stahl, 2013, 2017).

The decision to use one medication over another is based on clinical considerations that include the patient’s medical history, current lab values (especially kidney and liver function tests in older adults), history of present illness, previous recovery attempts, preferences, and potential interactions with current medications. Laws regarding the prescription and administration of these medications differ (SAMHSA, 2020a). Most notably, methadone is a Schedule II controlled substance; patients receiving methadone for MAT must have it administered from an opioid treatment program certified by SAMHSA. Opioid treatment programs are required to offer counseling, medical and vocational assessments, and treatments in addition to prescribed methadone (SAMHSA, 2020b). In states where practice may be limited for certain clinicians (e.g., advanced practice registered nurses), only a physician may prescribe methadone. To prescribe buprenorphine, an advanced practice nurse will need a buprenorphine waiver, which involves additional education (24 hours of free continuing education through the American Psychiatric Nurses Association and other professional organizations).

## Person-Centered Care and Reducing Stigma

Philosophical reorientation to addiction as a chronic, medical disease improves treatments and outcomes. Addiction resembles other chronic diseases such as diabetes and hypertension, and long-term recovery improves when addiction is viewed and treated as a chronic disease. McLellan et al. (2000) conducted a review of the literature to compare substance use disorders (“drug dependence”) with hypertension, asthma, and diabetes mellitus. They discovered similar characteristics in those conditions: genetic heritability, personal choices, environmental factors, recurrence of symptoms, and annual need for medical intervention. Individuals relapse because relapse or recurrence of symptoms is a core feature of addiction and all chronic diseases (Kelly et al., 2016; McLellan et al., 2000). It should not be met with judgement, stigma, or punitive measures.

Health care providers in long-term care facilities are often not adequately prepared to assess and treat substance use disorders (Sorrell, 2017). This may be due to lack of knowledge, or to a resistance that owes to stigma (Sorrell, 2017). Even when nurses wish to address residents’ substance use issues, there may be organizational resistance to appropriate assessment and treatment (Cabin, 2020). These barriers to treatment may be fueled by common misconceptions.

One common misconception is that a patient taking medications to maintain recovery from substance use is not fully in recovery. In addition, treatment facilities are less likely to offer medications for substance use disorders in older adults (Huhn et al., 2018). These two factors reduce the likelihood that an older adult will receive adequate treatment. However, the medications used for alcohol and opioid use disorders are approved by the FDA, and they significantly improve the length of recovery as well as reduce adverse events (e.g. overdose incidents, emergency room visits, mortality) related to substance use. These medications should be encouraged when individuals seek treatment for substance use disorders, and patients should be assisted in adhering to their prescribed medications.

Two other common misconceptions are related to the treatment of individuals with opioid use disorder: (1) that the prescription of opioids to treat acute pain may result in destabilization of recovery, and (2) that the individual’s report of pain may be a manipulation to obtain medications. There is no evidence that exposure to opioid analgesics in the presence of acute pain increases the rates of relapse in those with opioid use disorder. Rather, the stress associated with unrelieved pain is more likely to trigger relapse (Alford et al., 2006; Witkiewitz & Marlatt, 2004). Reports of acute pain accompanied by objective findings are less likely to be manipulative gestures than are reports of chronic pain with vague presentations. Care providers must break the cycle of distrust by acknowledging that fear of pain or undertreatment of pain is valid, rather than labeling the patient as “drug seeking” (Alford et al., 2006; Merrill et al., 2002).

Many healthcare providers are uncertain or feel uncomfortable about addressing “drug-seeking” behaviors in individuals with substance use issues. “Drug seeking,” an ill-defined term, is frequently associated with the health care provider’s own emotional response (Longo et al., 2000; Merrill et al., 2002; National Institute on Drug Abuse, n.d.). The term refers to a resident’s perceived manipulative, demanding behavior to obtain medication. A resident may suggest that the only solution to pain or psychological distress is a prescription of a controlled substance, often claiming that nonaddictive medications are ineffective or that he or she is allergic to those medications; the resident may describe symptoms that differ from objective evidence on physical examination. These behaviors are likely to elicit stigma with labels such as “addict” or “drug-seeking patient,” evoking a stereotype that elicits a negative response toward those with substance use issues. Stigma and its related negative responses reduce treatment engagement,

increase fear and anger in others, and can impact the care provided by staff (Ashford et al., 2019; Hadland et al., 2018; Yang et al., 2017). Although these behaviors may indicate substance use issues, they can also indicate a need for pain relief due to actual perceived pain, as well as anxiety and fear about inadequate pain management (National Institute on Drug Abuse, n.d.). Using clinical assessments and objective data along with subjective reports of symptoms can provide the confidence that nurses and healthcare providers need in order to provide treatment to those with substance use issues. Long-term care staff should approach these residents with open communication that emphasizes the staff's concern for residents' safety, in order to reduce anxiety and fear associated with these behaviors.

A supportive, nonconfrontational approach increases the likelihood that an individual with substance use issues will engage with the treatment team (Barry et al., 2002). Questions about substance use should be included in intake and follow-up appointments, but the more that nurses and healthcare providers show genuine interest in the resident's well-being and ask about overall health promotion behaviors, the more engaged the patient will be with the treatment team (Sacco & Kuerbis, 2015). Matter-of-fact language about substance type, quantity, frequency, alcohol use, and medication use (prescription and over the counter) can reduce stigma and prompt honesty (Kuerbis, 2020). Setting clear, firm limits on medication use, administration of medications, and alcohol use creates consistency for the resident. Behaviors associated with "drug-seeking" are more likely to be reduced when all staff maintain consistent policies and boundaries. Continuing education and team meetings produce consistency across caregivers and staff. Finally, gentle supportive feedback about patterns of problematic symptoms and behaviors should be provided. Reassuring residents in a nonjudgmental tone that staff and the facility will support them in seeking recovery by facilitating referrals and treatment is more likely to produce desired behavior change. Nurses and other providers can reassure the resident that a history of addiction will not prevent adequate pain and anxiety management.

Older adults who have lived in public housing have been found to have four or more adverse childhood events and a significant history of substance use issues (Larkin et al., 2017). This highlights a need for trauma-informed care. Increased adverse childhood events predict increased rates of anxiety, poverty, and homelessness (Larkin et al., 2017; Raposo et al., 2014; Roos et al., 2013). These individuals have complex comorbid and psychiatric issues that can be compounded by substance use and worsened when staff or facilities do not recognize and address their histories of trauma. Nurses and treatment teams can improve rapport and treatment adherence by providing trauma-informed care, which includes providing safety, transparent care with the goal of building trust, collaboration between treatment teams and residents that allows the resident to participate in decisions about care, empowerment, peer support with other residents who may have experienced similar issues with trauma and/or substance use, and care that demonstrates humility and responsiveness. Organizations and staff should feel comfortable in recognizing and addressing biases, stereotypes, sexual orientation, and trauma. It is better to assume that a resident has experienced trauma in life, rather than to risk triggering a resident with a trauma history by assuming that the resident lacks a trauma history.

### **Enhancing Motivation and Self-Efficacy**

The view of substance use disorders has shifted to a chronic disease model that emphasizes personal responsibility and symptom management. Motivation and self-efficacy are vital for these to occur. Motivation directly influences an individual's movement through stages of change and commitment to a plan to uptake health promotion behaviors, as well as the degree

to which the individual rates a health behavior as a priority (DiClemente, Nidecker, & Bellack, 2008). This can be a challenge in older adults who may view substance use as a “last pleasure” in their relatively limited future, further reducing motivation for reducing substance use (Klein & Jess, 2002). Residents who move into long-term care facilities typically do not do so for substance use treatment. Perhaps they are there because of a disease or cognitive issues, or they may be recovering from acute injury or surgery, or they may simply need additional supportive care. This presents a challenge to treatment for a substance use disorder in the long-term care setting; learning and utilizing basic motivational interviewing techniques may be one way to enhance motivation (Kaldy, 2010). Self-efficacy and motivation may not be as protective in older adults as in younger adults (Kuerbis et al., 2018), but motivational interventions appear to be effective in reducing alcohol use (Andersen et al., 2019). Boredom appears to be a particular driver of increased alcohol use (Kuerbis et al., 2018), so enhancing motivation and providing novel activities may help reduce substance use. In addition to nurses and staff making changes to their practices, long-term care facilities can address substance use issues through policies and procedures.

One option to enhance motivation and support for treatment of substance use disorders in older adults in long-term care is to make peer-support groups readily available. These could include twelve-step groups (e.g. Alcoholics Anonymous, Narcotics Anonymous) and SMART (Self-Management and Recovery Training) Recovery. Peer support enables nonclinical, nonprofessional assistance from others with similar issues and circumstances. Such options have been found to reduce substance use, improve treatment engagement, and improve self-efficacy (Tracy & Wallace, 2016). Peers in recovery at a facility can establish weekly 12-step meetings or SMART meetings. This may increase attendance because transportation is unnecessary, and it can enable residents to establish a recovery community. If anonymity presents a challenge given the facility’s design, nearby meeting locations and cost-effective older adult transportation may be another option. Representatives from organizations can also come to speak to groups about their experience with substance use, which may increase interest in meetings, self-acknowledgement of issues, and treatment engagement.

### **Policies and Procedures for Facilities**

A systems approach is more likely to influence an organization’s culture regarding those with substance use disorders and lead to greater change for more residents entering long-term care. Policies would include continuing education requirements, onboarding education regarding substance use, standardized policies for substance use communicated to residents and families prior to admission, procedures to address substance use issues once the individual is in long-term care, and establishing a collaborative care model with a strong referral network (Kaldy, 2010).

Institutional barriers to knowledge should be addressed through organizational policy (White et al., 2015). Continuing education related to substance use disorders should be required of all providers, including nurses and clinical assistants. Such education could be required at an employee’s hire date, and facilities can hold yearly review with staff. Topics might include chronic pain, opioid drug use, and motivational interviewing, as well as how to identify and address substance use issues and addiction (Sorrell, 2017).

Education has commonly focused on alcohol and prescription drug abuse, which do appear to account for a majority of substance use issues in older adults. However, there are other considerations for illicit substance abuse as well. The legalization of medical marijuana presents unique challenges to long-term care facilities. Although it is unlikely that an individual will

suffer an abuse issue related to marijuana, it is necessary for care facilities to have succinct policies and rules regarding this substance (White et al., 2015).

Nurses are well positioned to address the needs of residents with problematic substance use. Nurses participate at every point of care, from the time when an individual is admitted through treatment in long-term care. Nurses can draft policies that consistently address residents' needs. The implementation of SBAR (situation, background, assessment, recommendation) or DRAW (diagnosis, recent changes, anticipated changes, what to watch for) handoff documents as well as electronic records improve communication among staff members and reduce the likelihood that substance use issues might be missed from one shift to the next (Sorrell, 2017).

Older adults with substance use issues may need additional support and structure to initiate and maintain their recovery. Cognitive impairments may prevent adequate self-monitoring of worsening symptoms of substance use or efforts to reduce use. In older adults, substances may have a greater effect in impairing cognition and impulse control, which places older adults at greater risk for reoccurrence of use and safety (Kuerbis, 2020). Nurses and clinical assistants can improve support by informing the treatment team and staff of substance use issues and current recovery status. Protocols to enhance monitoring of these individuals can improve long-term outcomes and length of recovery. Engaging family in the individual's treatment further enhances support. This may be initially challenging for family members who might feel nervous, scared, or even hostile toward addressing substance use in a parent or older adult. Educating family on substance use patterns, substance use disorders as chronic illnesses, and treatments may help empower them to engage as support persons for their family member.

Due to the increase in homeless older adults, establishing a collaborative care model is important. Collaborative care is cost-efficient, and it can increase the capacity of long-term care facilities with limited resources to provide care for previously homeless individuals, who frequently present with complex medical and mental health issues (Kaplan et al., 2019). Kaplan et al. (2019) have found that homeless older adults who have a case manager need less mental health and substance use treatment. Establishing connections to substance use treatment facilities and organizations that provide free or sliding scale healthcare services would be beneficial to those who were previously homeless. Case managers can help residents navigate the healthcare systems and provide a bridge to services. It is encouraged that nursing staff create well-coordinated referral plans to substance use treatment facilities when substance use issues arise, with a back-up plan for medically monitored withdrawal in a hospital (Kaldy, 2010). Implementing a collaborative care model with the long-term care facility (lead by case managers and nurses) placed at the center of the model is likely to improve recovery outcomes and reduce comorbidity and mortality for residents with substance use issues, regardless of previous homeless status.

Substance use issues in older adults present a complex problem to be addressed in long-term care facilities. Although there are fewer older adults with substance use issues than middle-aged adults with substance use issues, older adults' comorbid chronic diseases, cognitive issues, and metabolic changes worsen outcomes significantly in those who misuse or abuse substances. Clinical considerations and adjustments made by nurses, clinical assistants, other providers, and facilities can improve the care and outcomes of these individuals. These considerations should continue to be addressed and implemented to improve the overall well-being of these residents in long-term care facilities.

Table 1. Signs and Symptoms of Potential Substance Use Issues in Older Adults

Anxiety	Memory loss
Blackouts	New onset difficulty in decision making
Confusion	Poor hygiene
Depression	Poor nutrition
Falls, bruises, burns	Seizures, idiopathic
Family problems	Sleep issues
Headaches	Social issues, isolation
Incontinence	Unusual response to medications
Legal difficulties	
Adapted from Barry, Blow, & Olsen (2002)	

Table 2. *DSM-5* Criteria for a Substance Use Disorder

<p>≥2 criteria within the previous 12 months = substance use disorder</p> <ol style="list-style-type: none"> <li>1. Taking the substance in larger amounts or for longer than intended</li> <li>2. Wanting to cut down or stop using the substance but being unable to</li> <li>3. Spending a lot of time obtaining, using, or recovering from use of the substance</li> <li>4. Craving and urges to use the substance</li> <li>5. Not meeting role requirements at work, home, or school because of substance use</li> <li>6. Continuing to use despite social/interpersonal substance-related problems</li> <li>7. Giving up or reducing important social, occupational, or recreational activities because of substance use</li> <li>8. Recurrent use in hazardous situations</li> <li>9. Continued use despite knowledge of persistent or recurrent physical or psychological issues that is caused or exacerbated by substance use</li> <li>10. Tolerance</li> <li>11. Withdrawal</li> </ol>
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