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Abstract

Substance use disorders (SUDs) and mental health problems frequently co-occur. SUDs are one of the most common psychiatric diagnoses in older adults. The purpose of this chapter is to discuss SUDs among LGBT elders. Information is presented on the scope of SUDs, prevalence and patterns of use, SUDs and aging comorbidity, assessment, diagnosis, and treatment of LGBT elders. This chapter provides the reader with a baseline for understanding issues that impact and influence LGBT elders' substance use. There is no suggestion that LGBT status is synonymous with addiction or mental illness disorders. Thus, the chapter explores the extent to which SUDs exist among LGBT elders.

Keywords

Substance use disorders · Addiction · Mental health · Alcohol · Drugs · Prescription medication

Overview

Substance use disorders (SUDs) are recognized as a public health issues in the United States and in many parts of the world. The reasons people use and/or abuse alcohol and other drugs are varied, ranging from use to cope with stress, pain, and to escape, to a means to relax and socialize, to being accepted by peers, and others.

Rarely do people say that they consume alcohol because they like the taste or use drugs because they are good for them. For many LGBT persons, the use of alcohol is an intrinsic part of the gay bar scene, which is a cultural norm of the gay community. For many LGBT elders who grew up during a time of secrecy about their sexual orientation and gender identity, the gay bar represented the only safe place for socialization. As many LGBT adults age, they become isolated, especially as a result of disability and chronic illness, and substances become a means to deal with isolation. In this chapter, we examine issues

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related to substance used, including mental health concerns, for LGBT elders.

Learning Objectives

By the end of the chapter, the reader should be able to:

1. Identify issues of SUDs for LGBT elders.
2. Understand the co-occurrence of SUDs and mental health concerns for LGBT elders.
3. Identify issues related to assessment, diagnosis, and treatment of SUDs in LGBT elders.
4. Identify policy concerns for addressing SUDs among LGBT elders.

Introduction

Currently, almost half of men and slightly over half of women over the age of 60 consume alcoholic beverages (Barnes et al. 2010) and most do not abuse alcohol. The majority of older adults are considered social drinkers. In general, alcohol consumption decreases with increasing age (International Center for Alcohol Policies [ICAP] 2014). Alcohol and drug use in older adults can be late-onset or one that began in young adulthood. Nevertheless, SUDs, which include alcohol, drugs, prescription medication, nicotine, and caffeine (Diagnostic and Statistical Manual of Mental Disorders 2013), among older adults are major and growing problems (Substance Abuse and Mental Health Services Administration [SAMHSA] 2008). The extent of the problem may be greater than suspected because of a misconception that older adults do not abuse alcohol and other drugs (AODs); consequently, healthcare professionals do not need to worry about SUD in this population. As a result of these misperceptions, healthcare professionals typically are the first to identify SUDs in elderly persons and to screen infrequently for substance abuse in their older patients.

For LGBT elders, the issue of underdiagnosis and gross underestimation of SUDs may be even greater because they have fewer resources in the community and within healthcare systems for prevention, earlier diagnosis, assessment, and treatment, and they may not seek services or ask for assistance (Ellison 2012; Jessup and Dibble 2012). Thus, as the baby boom cohort reaches retirement age, it encounters a healthcare system ill-prepared to deal with older adults with SUDs (Doweiko 2015).

SUDs are the third most common psychiatric diagnosis in older adults (Luggen 2006). The presence of both substance abuse and mental illness within a person is known as co-occurring disorder (COD). Although the majority of LGBT elders are in good mental health, significant percentages have symptoms of depression, anxiety, and AOD abuse higher than the general population (King et al. 2008; SAMHSA 2012). Limited information on the actual rates of SUDs among LGBT elders suggests that substance use among this population is highly correlated with poor mental health (Conron et al. 2010) and is a response to stressors related to violence, discrimination, internalized homophobia, low self-esteem, loneliness, stigma, and experiences of victimization based on sexual orientation and gender identity or expression (Frederiksen-Goldsen and Muraco 2010). In comparison with the general population, LGBT persons are more likely to use alcohol and drugs, have higher rates of substance abuse, are less likely to abstain from use, and are more likely to continue heavy drinking into later life (SAMHSA 2012). Lesbians and gay men perceive themselves to be at increased risk of SUDs, have an increased need for treatment, and face barriers to treatment. Moreover, the rates of alcohol consumption among lesbians and gay men do not seem to decrease with age as quickly as they do among heterosexuals (Healthy People 2010 2010).

The purpose of this chapter is to identify SUDs issues pertinent to LGBT elders. Given that SUDs and mental health frequently co-occur, reference is made to both SUDs and mental illness throughout this chapter. Information is presented on the scope of SUDs; prevalence and patterns of use; alcohol, drugs, and aging

comorbidity; detection, assessment, and diagnosis of SUDs; and treatment and intervention of LGBT elders. Finally, discussion of implications for policy is presented. The intent of this chapter is to provide the reader with baseline information for understanding issues that impact and influence LGBT elders' substance use behavior. Considerable individual variation exists regarding LGBT elders on the basis of age, gender, sexual orientation, and gender identity or expression. We stress that being LGBT is not synonymous with having an addiction (Beatty and Lewis 2003) or mental health disorders (see Chap. 23 for additional information on mental health).

The Scope of SUDs

Alcohol is the most commonly abused substance by elderly people; approximately 15 % of older drinkers have a concurrent drug abuse disorder (Ellison 2012). Prescription medication misuse (i.e., non-medical use) and abuse are growing public health problems among older adults in the United States. Most misused medications are obtained legally through prescriptions. Usually, problematic prescription medication use by older adults is unintentional and falls into the misuse category, though it can progress to abuse if they continue to use a medication for only the desirable effects it provides (Addiction Technology Transfer Center Network [ATTC] 2009). Regardless of age, individuals who seek a prescription with the aim to use the medication inappropriately and who may have already become addicted present with certain characteristics and behaviors (see Table 24.1).

Older adults are at high risk of medication misuse because of conditions associated with pain, sleep disorders and insomnia, and anxiety. Elders are more likely than their younger counterparts to receive prescriptions for psychoactive medications with misuse and abuse potential (e.g., opioid analgesics, benzodiazepines) (Administration on Aging 2012). According to Basca (2008), medication for persons age 65 and

older account for one-third of all medications prescribed, accounting for only 13 % of the population in the United States. Older women are at higher risk because they are more likely to use psychoactive medications, usually associated with divorce, widowhood, lower income, poorer health status, depression, and/or anxiety. Elderly women take an average of five prescription medications at a time for longer periods of time compared to older men (Basca). Prolonged use of psychoactive medications has been associated with confusion, falls, hip fractures, loss of motivation, memory problems, difficulties with activities of daily living, declines in personal grooming and hygiene, and withdrawal from normal social activities in older adults. The use of opioid analgesics can lead to excessive sedation, respiratory depression, and impairment in vision, attention, and coordination (Simoni-Wastila and Yang 2006). Moreover, adverse drug reactions are more common among the elderly.

Due to multiple chronic illnesses, an elderly person may be under the care of more than one doctor, none of whom may be fully informed about the complete range of medications the patient is taking. As drug regimens become more complex, there is increased probability of error by the patient as well as a greater potential for drug interactions. The chance of drug interactions is further complicated by an older adult's use of over-the-counter drugs. Many medications that once were available only by prescription are now available without one. Older adults take seven times more over-the-counter drugs than do persons of any other age-group (Kinney 2011). Unfortunately, physicians must rely on patient self-report about the type, dosage, and frequency of over-the-counter drugs being taken.

Many prescribed and over-the-counter drugs can interact with alcohol. Physiological changes that occur with aging that affect drug distribution and metabolism can contribute to the increased risk of drug-alcohol interactions. Certain medications commonly taken by older adults (e.g., aspirin, oral anticoagulants, antihistamines, oral medication for diabetes, pain medication) can present problems in the presence of alcohol. While the elderly exhibit alcohol and other drug

Table 24.1 Characteristics of prescription-seeking persons

Unusual behavior in the waiting room or extremes of either slovenliness or being over-dressed
Assertive personality, often demanding immediate attention
Having unusually detailed knowledge of controlled substances and/or giving their medical history with textbook symptoms, or, in contrast giving evasive or vague answers to questions regarding their medical history
Stating they have no regular doctor or health insurance, or they are reluctant or unwilling to provide that information
Making specific request for a particular controlled drug and unwillingness to consider a different drug that is suggested as an alternative
Not showing much interest in their diagnosis and not keeping an appointment for further test, or refusing to see another professional for consultation
Appearing to exaggerate medical problems
Exhibiting mood disturbances, suicidal thoughts, lack of impulse control, thought disorders, and/or sexual dysfunction, all of which may be an indication of the misuse of medications
State that they must be seen right away
Want an appointment toward the end of office hours
Call or come in after regular office hours
State that they are just traveling through town and visiting friends or relatives
Present with physical problems that can only be relieved with narcotic drugs
Present with anxiety, insomnia, fatigue, or depression that can be reduced with stimulants or depressants
State that non-narcotic pain relievers do not work or that they have an allergic reaction to them
Claim to be a client of another health professional who is not available
State that their prescription has been lost, spoiled, or stolen and needs replacing
Request refills more often than originally prescribed

Adapted from Department of Justice, Drug Enforcement Administration, Office of Diversion Control (1999)

(AOD) use, illicit drug use (e.g., marijuana, cocaine, heroin) is low (Kinney 2011). However, illicit drug use may be increasing in a small percentage of the elderly population, such as the baby boomers (SAMHSA 2006). Illicit drug use in elders is linked to long-term drug use. According to Simoni-Wastila and Yang (2006), “older addicts may simply represent younger addicts who have survived their drug-use disorder” (p. 383).

By 2020, it is estimated about 2.7 million older adults will present with a drug addiction (Colliver et al. 2006). Estimating the number of LGBT elders among those with SUDs is difficult for the following reasons: Many LGBT persons do not disclose their LGBT status, substance abuse programs do not conduct outreach specific or implement LGBT-inclusive services to this population, intake and application forms do not contain questions about sexual identity, and LGBT persons have difficulty fully accessing

substance abuse prevention and treatment services (Wilkinson 2008). Although much less is known about bisexual and transgender men and women, they may be at increased risk of substance abuse because in addition to being discriminated against by the heterosexual community, they are frequently further marginalized by the gay and lesbian community.

Prevalence and Patterns of Use

The patterns of substance use and associated problems vary among the older adults, as well as the reasons for abusing substances. For some of the elders, substance abuse is linked to the stresses of aging. In behavioral terms, the best predictor of future behavior is past behavior, especially true for how someone will handle growing old. For example, those who have

demonstrated flexibility throughout their lives will adapt well to stresses associated with aging. In addition, individuals with strengths and resiliency will adjust more readily to age-related stresses (Kinney 2011). Stresses of aging include, but are not limited to the following: (a) social stresses in which aging is equated with obsolescence and worthlessness, the process of receiving medical care and paying medical bills, and inadequate insurance coverage, especially for preventive services; (b) psychological stresses, with the greatest one for the elderly being loss (e.g., illness and death of family and friends, geographical separation of family, earned income, losses accompanying retirement); (c) biological stresses including physical disability, depressive illness with a physiological basis such as changes in the levels of neurochemicals, and dementia; and (d) iatrogenic stresses (harm caused by efforts to heal), which are by-products of the healthcare system and its insensitivities to elders' unique physiological and psychological changes. Usually, iatrogenic stresses are the result of overprescribing medication, failing to take into account the way the elderly metabolize medications, and ignoring that alcohol is also a toxic drug (Kinney). Kinney points out that as people age, they become less similar to one another and more individualistic; therefore, service providers should pay more attention to individual differences among elders.

Attention to alcohol use among older adults is important even when it does not qualify as abuse because it may cause or aggravate a range of health problems (Doweiko 2015; Kinney 2011). As people age, they become more sensitive to the effects of alcohol and medication, requiring less of the substance to feel its effects. Also, older adults have more physical and mental health issues than do younger adults (Ruscavage et al. 2006). Medical comorbidity in the older adults requires adequate monitoring, especially because the addition of substance abuse (resulting in multimorbidity) can complicate accurate diagnoses, including the length of time in order to make one. Multimorbidity makes it difficult to find a treatment that takes into account contradictions,

side effects, and drug interactions between substances, and affects the evolution of disease and the patient's functional status and his or her survival (Incalzi et al. 1997; Valderas et al. 2009).

Addiction rates are high among LGBT populations because of higher rates of depression, a need to escape from the constant presence of social stigma and homo/transphobia, efforts to either numb or enhance sexual feelings, to ease shame and guilt related to LGBT identity, and for some LGBT persons, peer pressure (www.recovery.org/topics/find-the-best-gay-lesbian-bisexual-transgender-lgbt-addiction-recovery-centers/#). Most LGBT elders report societal factors (e.g., discrimination, hate crimes, historical legal prohibitions on sexual behavior) as the reason for an increased prevalence of SUDs. Other anti-LGBT discrimination in situations that are unique to or particularly difficult for older people includes discrimination in housing, medical treatment, and public accommodations. Many LGBT elders are open about their sexuality and gender identity, but others remain closeted because they feel vulnerable and fear discrimination, abuse, or social condemnation. In addition, closeted LGBT elders may experience a certain level of stress when they come out later in life. These feelings lead to stressors for which they might use AOD as a means of coping or to reduce stress. LGBT persons across the age spectrum experience stigma, minority stress, and anti-gay/anti-trans social prejudice (Stevens 2012).

Today's older LGBT persons came of age when there were very few places in which they could safely express their sexuality or identity. One such place was gay bars, which play a central role in the LGBT community. Gay bars offer a place where LGBT persons might go to socialize without fear of ridicule, to meet potential partners, to relax, or to learn about one's sexuality and its implications for daily life (Doweiko 2015). Gay bars serve multiple functions for LGBT persons and have been described as a combination of bar, country club, and community center (http://www.agingincanada.ca/lgbt_older_adults.htm). Substance abuse, especially alcohol, is a large part of life of some segments of the LGBT community (SAMHSA 2012).

Alcohol, Drugs, and Aging Comorbidity

The effects of AOD on older adults are quite different than on younger adults, the majority of which stem from physiological changes associated with the aging process. Adults over the age of 65 have at least one chronic illness, which can increase their vulnerability to the negative effects of alcohol and/or drug consumption. In addition, specific age-related changes affect the way an older person responds to alcohol: (a) decrease in body water and increase in fat content, (b) increased sensitivity and decreased tolerance to alcohol, and (c) decrease in the metabolism of alcohol in the gastrointestinal tract. Each of these physiological changes results in a greater concentration in the blood system and quicker intoxication for older adults (SAMHSA 2008). The effects of alcohol on reaction time in older adults may well be responsible for some of the accidents, falls, and injuries that are prevalent in this age-group (Doweiko 2015). The interaction of age-related physiological changes and the consumption of high levels of AODs can trigger or exacerbate other serious health issues among older adults (see Table 24.2). Conversely, small amounts of alcohol have been shown to provide health benefits in older adults who do not have

Table 24.2 AOD abuse and comorbidities in older adults

Malnutrition
Cognitive impairment
Decreased bone density
Gastrointestinal bleeding
Alcohol-related dementia
Sleep pattern disturbances
Cirrhosis and other liver diseases
Increased risk of hemorrhagic stroke
Mental health problems, including depression and anxiety
Impaired immune system and capacity to combat infection and cancer
Increased risk of hypertension, cardiac arrhythmia, myocardial infarction, and cardiomyopathy

Adapted from SAMHSA (2008)

certain medical conditions, taking certain medications, or a history of AOD abuse. For example, alcohol has been shown to be a protective factor against coronary heart disease, heart failure, and myocardial infarction, particularly in older men (Djousse and Gaziano 2007; Gronbaek 2006). For postmenopausal women, moderate drinking can contribute to an improvement in bone density and a reduction in the risk of osteoporosis (Rapur et al. 2000). In both elderly women and men, light-to-moderate drinking is associated with a reduced incidence of type 2 diabetes mellitus (Djousse et al. 2007). Elders who consume moderate amounts of alcohol have demonstrated improved cognitive functioning compared to those who abstain or report heavy drinking (Deng et al. 2006; Stampfer et al. 2005; Xu et al. 2009), and delay in cognitive decline in older women (Stott et al. 2008). Other studies support psychological benefits of moderate alcohol consumption among the elders, including reduced stress and improved mood and sociability (Bond et al. 2005; McPhee et al. 2004).

Because of age-related physical changes, moderate alcohol consumption is defined as one standard drink (e.g., 1 ½ oz of liquor, 12 oz of beer, or 5 oz of wine) (National Institute on Alcohol Abuse and Alcoholism [NIH] 2005) in a 24-hour period, and hazardous alcohol use is defined as more than three drinks in one sitting or more than seven drinks in a 7-day period (Drew et al. 2010). It is important to note that, depending on factors such as the type of alcohol and the recipe, one mixed drink can contain from one to three or more standard drinks (NIH). Although moderate alcohol consumption has demonstrated some beneficial effects, elders should not increase their alcohol consumption for health reasons. Alcohol consumption among the older adults requires careful monitoring along with other lifestyle factors (ICAP 2014).

The age at which a person begins to use substances and eventually progresses to abuse has implications for effects in later life. Elderly persons with SUDs can be categorized as early-onset or late-onset abusers. For early-onset abusers, substance abuse develops before age 65. Early-onset abusers show higher incidences of

psychiatric and physical problems than do late-onset abusers. For late-onset abusers, substance abuse behaviors are thought to develop subsequent to stressful life situations (e.g., death of a partner, retirement, social isolation). Late-onset abusers typically have fewer physical and mental health problems than early-onset abusers (Martin 2012). In both early- and late-onset abusers, the physical changes associated with aging can skew tolerance in elders. The more alcohol or drugs used by a person is an indication of an increase in tolerance. The signs of tolerance include more substance consumed, in large quantities, and over a longer period of time than initially intended. The case of Stanley (below) illustrates an elder gay man presenting risk factors and comorbidities of substance abuse.

Discussion Box 24.1: The Case of Stanley

Stanley is a 71-year-old white gay man. He was referred to the community alcohol treatment program after having numerous falls. Stanley grew up in a large city with a visible and vibrant LGBT community. He considered himself an active member of that community until about age 53. In fact, he met his partner there and they had been together until his death two years ago. Admittedly, Stanley was a moderate-to-heavy drinker during his 30s, 40s, and 50s. He had a period of abstinence for about 15 years. Upon the death of his partner, Stanley started to drink heavily. This was the first time that Stanley has lived alone in over 40 years. He displayed symptoms of insomnia, depression, and suicidal ideation. His doctor prescribed antidepressant medication, which Stanley has been on for the last 15 months.

Stanley attended the substance abuse treatment program for about two sessions before disengaging. Although he continued to attend session erratically, his rationale for doing so was that the sessions were not helpful and required too much of his time, and he believed that drinking provided him

with more “balance” than did either the medication or counseling. Stanley was deemed to have the capacity to make his own decisions. Noticeably, his physical and mental health deteriorated, and he had multiple burses from frequent falls and talked often about how life was not worth living alone. Stanley refused any additional treatment. At such time, the treatment and psychiatric considered Stanley as a threat to himself. He was admitted to inpatient treatment and a psychiatric evaluation was done.

Questions

1. What is the recognizable association between major life events, psychiatric disorder, and alcohol abuse?
2. What are the implications of Stanley’s long period of sobriety/abstinence and relapse?
3. What type of treatment plan would you consider for Stanley?
4. What resources and service professionals would you involve in the treatment for Stanley?

Comorbidities in LGBT elders with mental illness present unique challenges. These elders have quadruple stigma (e.g., sexual orientation/gender identity or expression, mental health disorder, SUD, age). The stigma faced may affect LGBT elders’ psychological health, adding additional stress and anxiety and leading to increases in substance use and other high-risk behaviors. Research Box 24.1 contains a study of the prevalence of mood, anxiety, and SUDs for older adults. Keep in mind that the level of minority stress varies depending on the life content and experiences of the individual (Stevens 2012). Literature suggests that LGBT elders with comorbidities experience life circumstances and exhibit responses to circumstances that may exacerbate their internalized stereotypes, making them less likely to seek help for substance abuse or mental health issues.

Research Box 24.1

Gum, A. M., King-Kallimanis, B., & Kohn, R. (2009). Prevalence of mood, anxiety, and substance-abuse disorders for older Americans in the national comorbidity survey-replication. *American Journal of Geriatric Psychiatry, 17*(9), 769–781.

Objective: This study aimed to explore the prevalence of psychiatric disorders among older adults in the United States by age (18–44, 45–64, 65–74, and 75 years and older) and sex. Covariates of disorders for adults age 65 and over were explored.

Method: A cross-sectional epidemiologic study using data from the National Comorbidity Survey-Replication was used. The participants were representative of a national sample of community-dwelling adults in the USA. The World Health Organization Composite International Diagnostic Interview was used to assess Diagnostic and Statistical Manual of Mental Disorders (4th ed.) psychiatric disorders.

Results: Prevalence of 12-month and lifetime mood, anxiety, and substance use disorders was lower older adults (65 years and older) than younger age-groups: 2.6 % for mood disorder, 7.0 % for anxiety disorder, 0 for any substance use disorder, and 8.5 % for any of these disorders (for any disorder, 18–44 years = 27.6 %, 45–64 years = 22.4 %). Among older adults, the presence of 12-month anxiety disorder was associated with female sex, lower education, being unmarried, and three or more chronic conditions. The presence of a 12-month mood disorder was associated with disability. Similar patterns were noted for lifetime disorders (any disorder: 18–44 years = 46.4 %, 45–64 years = 43.7 %, and 65 years and older = 20.9 %).

Conclusion: This study documented the continued pattern of lower rates of formal diagnoses for elders. These rates likely underestimate the effects of late-life

psychiatric disorders, given the potential for underdiagnosis, clinical significance of subthreshold symptoms, and lack of representation for high-risk older adults (e.g., mentally ill, long-term care residents).

Questions

1. If LGBT elders were included in this study, do you think that the results would have been the same, different, or similar?
2. In what ways could this be redesigned to explore prevalence of mood, anxiety, and SUDs for LGBT elders?
3. Do you think that criteria for SUDs in the DSM-5 would change the interpretation of these data?

Detection, Assessment, and Diagnosis

Detection of substance abuse in the older adults is difficult because the signs and symptoms of substance abuse and aging are similar. Older adults have more medical problems than do younger persons, which in the early stages of SUDs often mimic the symptoms of other health conditions. In addition, older adults who abuse substances tend to attribute the physical complications caused by their substance use to the aging process. Similarly, physicians and family members aid in this assumption because they do not inquire about possible substance abuse in elderly persons (Doweiko 2015; Drew et al. 2010). Some family members believe that the elders have reached an age in life in which they have earned the right to drink and to not have their behavior questioned (Kinney 2011). Another reason for difficulty with detection is that social isolation is often both a reason for and consequence of substance abuse (see Chaps. 22 and 31). However, for older adults who are socially active, their peers might encourage drinking well into their later adult years

(Brennen et al. 2010). Other ways in which detection of SUDs are difficult to detect are that they have non-specific presentations and rarely demonstrate the traditional warning signs of an addiction (e.g., legal problems, workplace behaviors) (Drew et al.). For elders still in the workforce who have SUDs, missing days from work because of substance abuse problems are explained away as age-related conditions or stress of taking care of a sick spouse or partner (Dow-eiko). After retirement, typically elders have more time on their hands and, for those who may have been functioning substance abusers while working and able to manage their addiction, may begin to manifest symptoms in retirement as their substance abuse progresses (Zak 2010).

Elders tend to hide inappropriate AOD usage, making detection more difficult. The SAMHSA Guidelines (i.e., Screening, Brief Intervention, Referral to Treat [SBIRT], <http://www.samhsa.gov/prevention/sbirt/>) recommends that the first step in a process of detection is a screening, using a test like the Short Michigan Alcohol Screening Instrument-Geriatric Version (SMART-G) (Blow et al. 1992), which is tailored to the needs of older adults. The SMART-G contains ten questions about the person's estimation about quantity of alcohol consumed, eating habits, physical response after drinking, memory, reasons for drinking, conversations with medical personnel about one's drinking, and the use of rules to manage one's drinking. If an elderly patient answers "yes" to two or more of the items on the SMART-G, it is indicative of an alcohol problem. Another commonly used screening instrument is the CAGE (Ewing 1984). The CAGE contains four "yes/no" question about drinking: (a) feeling one should "cut down" on drinking, (b) felt "annoyed" by others criticizing one's drinking, (c) felt "guilty" about one's drinking, and (d) needing a drink in the morning as an "eye opener." A "yes" response of two or more is considered clinically significant. The patient's responses are used to discuss the need to cut down on the amount of alcohol consumed. If the patient does not see a need for change, a referral should be made to a mental health practitioner or a geriatric psychiatrist

(Naegle 2012). Both the SMART and CAGE are psychological screening instruments. It is important to note that a screening is not a diagnosis, rather a means to identify at-risk AOD use.

If the screening process suggests the presence of a SUD, the next step in the process is to determine the severity of the SUD. This step is known as assessment. A comprehensive assessment involves collection of data about the quantity and frequency of use, and the social health consequences of drug use, including nicotine, prescription, over-the-counter, herbal and food supplements, recreational drugs, and alcohol (Naegle 2012). In addition, a comprehensive assessment should include a thorough physical examination along with laboratory analysis and psychiatric, neurological, and social evaluations (Martin 2012). Given that many elders take numerous medications, a basic assessment of their medications may require the shopping bag approach in which elders bring in all of their medications (i.e., a shopping bag filled with medication). The assessment of elderly substance abusers involves a biomedical, psychosocial approach in which it is determined whether the patient has a biological disease (e.g., depression that is producing the abuse) or whether the substance abuse has produced a biochemical brain disorder (e.g., dementia, delirium). Both the medical complications from the abuse and medical problems exacerbated by drug dependence must be examined. Psychological distress (e.g., anti-gay/anti-trans prejudices) can induce addictive behavior, requiring psychological interventions to address the problem. Elderly LGBT persons may have a complex combination of functional and social behaviors that exacerbate substance abuse and complicate treatment. Thus, the treatment team must elicit basic biomedical psychosocial information during the diagnostic phase and then use these data to construct an appropriate treatment approach (Geriatric Substance Abuse-Dementia Education & Training Program n.d.). Finally, assessment should consider the spiritual concerns and beliefs of LGBT elders (see Chap. 27). This understanding may aid in the recovery process and relapse prevention.

During assessment and diagnosis, the assessor must be cognizant of several issues to accurately diagnose SUDs in elderly adults. First, memory loss, particularly short-term, can sometimes cause an older person to forget to take his or her medication or to take too much unintentionally. Similarly, the elder person may have difficulty recalling information accurately to answer questions during an assessment interview. Second, the interplay of health issues makes diagnosing and treating SUDs in elders more complicated than for other age-groups (Ruscavage et al. 2006). Third, the diagnostic criteria in the *Diagnostic and Statistical Manual* were validated on young and middle-aged adults. Although tolerance of a substance is one diagnostic criterion for SUDs, it may not apply because of physiological changes related to aging, which may result in less alcohol intake with not apparent reduction in intoxication. Similarly, elders with late-onset substance abuse may not experience physiological withdrawal when the substance is suspended. Fourth, a criterion that describes the negative impact of substance abuse on work functions may be irrelevant for elders who live alone. The result is that abuse among the elderly may be miscalculated. In addition, the criterion of giving up activities may be of little use when assessing a retiree who has fewer regular activities and responsibilities to give up (Menninger 2002). Finally, assessment usually takes place over several days. Thus, the assessment process can be fatiguing for elderly patients. Other challenges when working with the elderly population include service providers' biases and belief about aging, substance abuse, and LGBT populations, and denial of substance use by the elderly (Martin 2012).

Treatment and Intervention

The majority of elders with SUDs or mental health problems, especially LGBT elders, do not receive the treatment they need (Martin 2012). LGBT persons who are in need of treatment for

SUDs face several substantial dilemmas: (a) a lack of culturally relevant trained staff and specialists, (b) staff members and clients who will attempt to impose their own ideological beliefs on them, (c) programs that do not address issues related to sexual identity or gender expression, and (d) programs that do not address issues related to traumatic childhood experiences (Cochran et al. 2007). In a survey of substance abuse treatment providers' attitudes and knowledge about LGBT clients, ATTC (n.d.) found half had no education about lesbian, gay, and bisexual persons, and 80 % had no education regarding transgender persons. Although half of the counselors in the study had worked with lesbian, gay, or bisexual clients in the past and few had worked with transgendered persons, the majority reported that they lacked information about many important issues that affect LGBT clients. The counselors reported that they had little or no knowledge of LGBT persons regarding the following: legal issues (73 %), domestic partnership (69 %), family issues (54 %), internalized homophobia (48 %), and coping strategies (37 %). However, 25–50 % of substance abuse counselors had positive attitudes about LGBT clients. The counselors recognized that they needed training in these areas to be more effective with all clients, especially for relapse prevention and aftercare planning and to be aware of the potential stresses in the client's life related to their sexual orientation or gender identity.

Although the LGBT population is comprised of a unique group of individuals with a special set of commonalities, as a subpopulation, transgender persons require additional considerations in the treatment process. One vital consideration is the stage of transition in which the person is engaged. For example, a person who is in pre-surgery status and is living the role of the "to be assigned" gender might encounter a range of policies in an inpatient treatment setting. Such policies may range from non-acceptance to acceptance with conditions (e.g., separate living quarters and bathrooms or separate rooms with access to generic bathrooms) (Beatty and Lewis 2003).

For LGBT persons, certain questions come up in the treatment process. Some questions deal with sexual identity and others with trauma (see Table 24.3).

Treatment protocol and treatment success are influenced by several factors including severity of substance use, type(s) of substance used, and whether substances are used in combination with other substances. Therefore, the types of drugs abused, the location of abuse, and potential triggers for relapse present differently depending on the population (Singh and Lassiter 2012). Regardless of age or gender, polysubstance abusers present more challenges in the treatment process because substances used in combination increase risk factors (Rowan and Faul 2011). Emerging evidence-based research supports the efficacy of a variety of pharmacological and psychotherapeutic interventions for SUDs and major psychiatric disorders in elderly persons. In light of comorbidities being associated with increased healthcare utilization and significant healthcare expenditures among elders, targeted prevention and early intervention can offset substantial costs to patients, their families, healthcare organizations, and the government (Bartels et al. 2005). In fact, an integrated approach to treatment of comorbidities results in far better outcomes. Using a multidisciplinary team to treat

comorbidities enhances cohesiveness of care and reduces conflicts between service providers. The argument is for both disorders to be treated as “primary” using a combination of different modalities such as outreach and case management, motivational techniques, psychotherapy, and psychopharmacology.

Motivational interviewing, cognitive-behavioral therapy, brief therapeutic interventions, and individual, group, and family counseling which are widely used in the treatment of SUDs have been implemented with elders (Martin 2012). Brief interventions, intervention (i.e., significant people in the person’s life collectively confront the person with their firsthand experiences of his or her substance use), and motivational interviewing, the least intensive treatment options, are recommended first with elderly substance abusers as a pre-treatment strategy or as treatment itself (Cummings et al. 2009; Ruscavage et al. 2006). Least-restrictive treatment options have been found to be effective; older adults respond better to age-specific group treatment and cognitive-behavioral therapy-based programs (Brown et al. 2006; D’Agostino et al. 2006). Some elders may be in need of intensive treatment such as inpatient/outpatient, detoxification, recovery or group home housing, and specialized outpatient services. The treatment approach should be tailored to LGBT elders’ individual circumstances and needs

Table 24.3 Service provider questions in SUDs treatment of LGBT persons

When does one raise the question of the client’s sexual identity if it appears to be a clinical issue?

Trust is one of the major factors in the therapeutic relationship. If sexual identity is presented as a clinical issue, then it may be relevant for the therapist to raise the issue. First, start with non-threatening questions. If the client remains closed and the topic clearly is a clinical concern, use more direct questions

Should the therapist reveal his or her own sexual identity?

If the facility is identified as LGBT specific, this may not be an issue except for non-LGBT staff. Non-identified facilities may have several concerns: (a) safety for the staff person, (b) acceptance by administrators, (c) acceptance by facility peers, (d) the purpose of revealing, (e) social lifestyle of the staff person, (f) the size of the LGBT community, (g) the impact of this information being revealed

Are there issues/challenges a transsexual person encounters when in treatment?

The stage of transition (i.e., pre-reassignment vs. post-reassignment surgery) will determine whether specific issues must be addressed

How concerned should service providers be with HIV antibody testing and counseling of LGBT population?

Research supports sexual activity and substance use as strong HIV risk-related behaviors. The elderly is one of the fastest growing groups to be diagnosed with HIV. There is a misperception that risk is somehow diminished with age and the topic is not discussed by health providers (Funders for Lesbian and Gay Issues 2004)

Adapted from Beatty and Lewis (2003)

(e.g., self-esteem, perceptual, cognitive, sensory, literacy, and language needs). The *Treatment Improvement Protocol (TIP) 26* (SAMHSA 2008) identified several key characteristics of treatment that contribute to positive outcomes for elders with SUDs. Given that the protocol is not specific to LGBT persons, as authors of this chapter we present the material to be LGBT inclusive (see Table 24.4). Equally as important in treatment is psychoeducation (i.e., teaching components of behavior change) in which elders receive information and gain knowledge about the risks of combining alcohol with medications and excessive alcohol use (Brown et al. 2006; D'Agostino et al. 2006; Doweiko 2015; Martin 2012). Often, LGBT elders with SUDs are in need of strategies for increasing social interactions and personal efficacy when refusing substances and/or peer pressure.

Being honest with oneself and others is a hallmark of efficacious treatment strategies. However, for LGBT persons, being open about their sexual identity presents several dilemmas in treatment: (a) If they come out, they face possible rejection and alienation; (b) if they do not come out, they are viewed as untruthful; (c) if they indicate their differences from heterosexual clients, they are seen as asking for special privileges

or jeopardizing other clients' recovery; and (d) if they accept generic treatment, their own recovery is jeopardized (ATTC n.d.). In light of these perceptions, counselors and service providers should work with LGBT elders to determine whether, when, and how to come out or to reveal their sexual identity while in treatment. In addition, attention must be given to the type of counseling (e.g., individual, group) that is more appropriate. Thus, counselors and service providers are required to have cultural competence related to the LGBT population, aging, and ethnic minority groups. For counselors and service providers who are not culturally competent in working with LGBT populations, it is best to acknowledge it and refer the client to someone with such competency.

Because of negative experiences of LGBT elders have had due to their sexual orientation or gender identity and expression, it is important for treatment interventionists to ensure that their treatment facility, office, and organization in which they work send a clear message that the environment is safe for LGBT persons to disclose their concerns. For example, displaying LGBT-friendly literature in the waiting room and offices or a "Safe Zone" or rainbow sticker on the front door of the building or reception area are symbols universally recognized as safe places. It is important first to seriously assess the safety of the service delivery environment before deciding to display such a symbol (Singh and Lassiter 2012). Deciding to disclose one's sexual orientation or gender identity or gender expression must be given serious consideration because although federal and a number of state statutes protect recovering substance abusers from many forms of discrimination, LGBT persons are not afforded the same protections in many areas of the United States (SAMHSA 2012).

Programs that provide treatment to LGBT persons must be particularly vigilant about maintaining client's confidentiality because the consequences of an inappropriate disclosure can have devastating consequences and implications for safety, employment, housing, and social services (SAMHSA 2012). In addition, special support group meetings (e.g., Alcoholics Anonymous)

Table 24.4 Characteristics for LGBT elder treatment positive outcomes

Emphasis on age-specific rather than mixed-aged treatment
Emphasis on sexual identity-specific characteristics
Use of supportive, non-confrontational approaches that build self-esteem
Focus on cognitive-behavioral approaches to address negative emotional states
Development of skills for improving social interaction and support
Involve support systems, including friends and family of choice
Appropriate pace and content for LGBT elders
Capacity to provide referrals to medical, mental health, aging, and LGBT-specific services
Counselors and service delivery personnel trained to work with LGBT elders

Adapted from SAMHSA (2008)

oriented toward the specific needs of LGBT elders must give consideration to addressing both age and sexual orientation or gender identity issues that are relevant to recovery. Unfortunately, such 12-step meetings are usually only found in large cities (Doweiko 2015). Further, 12-step programs can be unwelcoming of LGBT persons because of traditional religious persecution of sexual minorities (Shelton 2011). See Chap. 29 for additional discussion on the role of religious leaders in addressing LGBT elders.

Treatment services for LGBT elders with SUDs require knowledgeable service providers who are skilled in the aspects of aging, with cultural competence in LGBT issues, able to understand the effects of comorbidities, and able to integrate biomedical, psychosocial, and physiological risk factors for addiction. Service planning and delivery should follow a logical and sequential progression to increase more positive outcomes. Inclusion of various service professionals from across disciplines on the treatment team for LGBT elders is one way to potentially improve the quality of service.

Policy on SUDs

Substance abuse services need to address deep-rooted age discrimination and heterosexist philosophies that continue to permeate mainstream services. Advocates in the United States assert that policies should allow LGBT elders to access the most appropriate clinical service on the basis of need and that age and sexual orientation or gender identity must not be exclusion criteria (SAMHSA 2012). Although, historically, SUDs were thought to be more prevalent in younger LGB populations, much of the research and many treatment programs and protocols continue to ignore LGBT elders. A critical need exists for LGBT-specific standards of care and treatment protocols that are generally acceptable or sanctioned by national accreditation organizations. Such standards could be used as the basis for certification of clinical staff or licensing

of treatment programs, and as the basis for staff training programs (Healthy People 2010 2010). In addition, AOD screening should be part of all elders' annual medical examination. The administering of the CAGE by nurses should be part of the series of questions asked during a doctor's visit by patients.

When assessing LGBT persons with SUDs, treatment programs should incorporate more inclusive language into their assessment instruments and retain staff. Assessments include relationships with family of origin, family of choice and friends, level of community or systems support, social interactions, level of self-esteem, understanding of self-identity, and work issues (SAMHSA 2012) (see *A Provider's Introduction to Substance Abuse Treatment for Lesbian, Gay, Bisexual, and Transgender Individuals*). For transgender persons, it is important to address them based on the gender with which they identify. Similarly, assessment instruments should be sensitive to the age of the individuals and the presence of coexisting conditions in order to accurately measure the extent of the problem.

Although some efforts have been put forward regarding practice on SUDs for LGBT elders, an impact policy is needed to prioritize and fund prevention and intervention as a healthcare concern. Screenings for mental health concerns, including substance abuse, should receive equal focus as an emphasis just as is physical disorders and diseases among the elderly (e.g., cancer, arthritis, cataract). Although Medicare covers treatment for mental health issues, copayments can be prohibitive for elders with lower incomes. The Positive Aging Act, an amendment to the Public Health Service Act, is a policy alternative that could address SUDs in elders. First, the act could demonstrate ways of integrating mental health services for elders into primary-care settings. Second, it could support the establishment and maintenance of interdisciplinary geriatric mental health outreach teams in community settings where older adults reside or receive social services (Gage and Melillo 2011). In addition, because doctor shopping is a common occurrence among the elders, a need exists for

information sharing on prescription medication through as a state database.

Finally, it is important to establish an educational program on signs, symptoms, and risk factors of substance abuse, including LGBT-specific and age-related content as a part of a public health initiative. An educational program can serve the secondary purpose of helping LGBT elders understand the importance of medical evaluation and treatment for any health conditions, as well as promote their comfort with disclosing their sexual identity if it is clinically relevant. Too often, LGBT health issues are lumped together as if all LGBT elders are alike. Any educational program should address health and mental health issues contextually for lesbians, gay men, bisexual men and women, and transgender male-to-female and female-to-male. One avenue is to develop partnerships with LGBT-sensitive primary-care physicians and clinicians, therapists, and psychiatrists (SAMHSA 2012).

Summary

Research on SUDs in the aging population has increased; however, focus on LGBT elders remains somewhat limited. LGBT elders exhibit higher rates of SUDs than their heterosexual counterparts. Reasons for substance abuse range from discrimination and stigma to loneliness and a means of socialization. In general, elders have medical comorbidity and, the addition of SUDs and mental health disorders serves to further complicate diagnosis and treatment. In assessing and diagnosing LGBT elders for SUDs, it is critical to be aware of the vast differences within this population.

To be effective, service providers must understand the unique characteristics and challenges of LGBT elders with SUDs when assessing, diagnosing, and planning treatment. Whether LGBT elders have early or late onset of substance abuse, they will benefit from culturally specific strategies and comprehensive approaches.

Learning Exercises

Self-Check Exercises

1. What are some unique characteristics of LGBT elders who abuse substances?
2. What is the most commonly abused substance by elders?
3. Why is it difficult to estimate the number of LGBT elders with SUDs?
4. How difficult is it for LGBT elders to find AA groups that are specific to their needs?
5. What roles do gay bars play in the lives of LGBT persons?

Experiential Assignments

1. Interview an LGBT elder to determine what his or her specific needs would be in a support group (e.g., AA) designed specifically of LGBT elders.
2. Interview a substance abuse counselor, social worker, or medical professional/nurse to explore his or her knowledge about meeting the unique needs of a LGBT elder with SUDs and a mental health disorder.
3. Develop a manual on substance abuse and mental health resources in your local town or city region for LGBT elders.

Multiple-Choice Questions

1. Which type of treatment options is recommended first for elders with SUDs?
 - (a) Least costly
 - (b) Most comprehensive
 - (c) Least intensive
 - (d) Multilevel
2. Which type of medication is the elderly most likely to receive that has misuse and abuse potential?
 - (a) Psychoactive
 - (b) Diuretic
 - (c) Inhalants
 - (d) Anti-coagulant

- (3) What is the purpose of a substance abuse screening is to do which of the following?
- Identify a treatment protocol
 - Identify at-risk behavior
 - Make a diagnosis
 - Determine the existence of a family history of substance abuse
4. Which of the following is how comorbidity of substance abuse and mental illness be defined and treated?
- Both as secondary conditions
 - One as a primary and the other as a secondary condition
 - Both as primary conditions
 - One as a primary condition and the other as a symptom
5. Which of the following usually result in iatrogenic stress?
- Overprescribing of medication
 - Ignoring that alcohol is also a toxic drug
 - Failing to take into account the way the elderly metabolize medications
 - All of the above
 - None of the above
6. How are LGBT persons viewed if they do not reveal their sexual orientation or gender identity while in treatment?
- Secretive
 - Introverted
 - Selfish
 - Untruthful
7. Which of the following is ignored as a growing concern of LGBT elders in substance abuse treatment?
- HIV
 - Dementia
 - Illicit drugs
 - Substance-specific syndrome
8. Why are LGBT elders with comorbidities less likely to seek treatment?
- More medical problems than younger people
 - Internalized stereotypes
 - Religious reasons
 - Legally cannot be questioned about substance use
9. What is a unique challenge of residential substance abuse treatment that is specific to transgender adults?
- Age at which they come out
 - Post-reassignment surgery status
 - Pre-reassigned surgery status
 - Unwillingness to provide information
10. How many “yes” responses to questions on the CAGE or SMAR-G are indicative of a substance abuse problem?
- One
 - Two
 - Three
 - All

Key

- 1-C
2-A
3-B
4-C
5-D
6-D
7-A
8-B
9-C
10-B

Resources

CSAP Substance Abuse Resource Guide: Lesbian, Gay, Bisexual and Transgender Populations: <http://www.health.org/referrals/resguides.asp?InvNum=MS489>

LGBT Populations: A Dialogue on Advancing Opportunities for Recovery from Addictions and Mental Health Problems: www.samhsa.gov/recovery/doc/LGBTDialogue.pdf

National Association of Lesbian & Gay Addiction Professionals (NALGAP): www.nalgap.org

Preventing Alcohol and Other Drug Problems in the Lesbian and Gay Community: www.prta.com

Royal College of Psychiatrists (London) College Report CR 165. (2011, June). Our invisible addicts—First report of the older persons' substance misuse working group of the Royal College of Psychiatrists: www.rcpstch.ac.uk/files.../cr165.pdf
SAMHSA: A Provider's Introduction to Substance Abuse Treatment for LGBT Individuals (2012): www.store.samhsa.gov
The Center: LGBT Community Center: <http://gaycenter.org/recovery>

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