Substance Use Disorders in Long-Term Care

Building Safer Care Environments

Alcohol Use Disorder **Toolkit**

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How to use this toolkit

Frontline staff start with sections 1- 9 and the appendix for tools you can use Administrators can jump to sections 10-12 for leadership guidance. See Appendix A for a quick reference.

Scan QR codes for digital decision trees, roadmaps, and resources

This toolkit is designed for all rest home staff, including clinical and especially non-clinical roles, as well as administrators and leadership. An individual's relationship with alcohol may be complex and sometimes includes a clinically diagnosed use disorder. Supporting residents requires shared responsibility, consistent practice, and staff training.

1. Understanding how alcohol use, AUD, and stigma may affect each resident's health, safety, and quality of life.
2. Using routine screening as a supportive, nonjudgmental way to build trust and understand residents' needs and goals.
3. Partnering with residents (and families, when appropriate) to develop care plans that respect choice, promote safety, and minimize harm.
4. Reflecting and training regularly on respectful communication, implicit bias, trauma-informed care, and recognizing signs of intoxication or withdrawal.
5. Connecting residents and families to community resources that align with their preferences, values, and care goals.

Acknowledgments

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Massachusetts Department of Public Health
DPH

The toolkit follows a simple, consistent care pathway used throughout:

Not every resident will move through this pathway in a straight line. The goal is not perfection, but clarity, consistency, and dignity at every step.

Toolkit actions	Putting our values into practice	How it aligns
1. Learn how alcohol use, Alcohol Use Disorder (AUD), and stigma can affect each resident's health, safety, and daily life.	Dignity Comes First; Equity and Cultural Humility Are Essential	We know AUD is a health condition, not a personal failure. We respect each resident's life experience and how stigma, trauma, and background affect health.
2. Use screening in a kind, routine way to build trust and understand what matters to residents.	Safety Is a Shared Responsibility; Relationships Drive Outcomes	We use routine screening to reduce stigma and support safety. Asking everyone the same way helps residents feel safe, respected, and heard.
3. Work with residents (and families, when appropriate) to plan care that respects choice and supports safety.	Person-Centered Care Guides Our Work; Dignity Comes First	Residents help guide their care. We honor choice, focus on safety, and use harm reduction when abstinence is not the goal.
4. Practice and train on respectful communication, bias, trauma-informed care, and signs of intoxication or withdrawal.	Words Matter; Equity and Cultural Humility Are Essential; Staff Well-Being Sustains Care	We use respectful language, avoid blame, and keep learning. Training helps staff feel supported and helps residents feel safe.
5. Help residents and families connect to community supports that match their goals and needs.	Relationships Drive Outcomes; Person-Centered Care Guides Our Work	Care works best when we build strong relationships and connect residents to supports that fit their goals and lives.

Relationship-centered AUD care in rest homes

See Appendix B

As staff members at _____ , this statement reflects our commitment to safe, compassionate, and equitable care for residents with Alcohol Use Disorder (AUD) and active alcohol use. It is intended to guide daily practice, decision-making, and leadership actions across all roles.

Dignity comes first
- We recognize AUD as a health condition, not a moral failing.
- We treat every resident with respect, compassion, and humanity.
- We honor resident autonomy while prioritizing safety.
- We recognize that staff dignity and resident dignity are inseparable.

Words matter
- We use person-first, non-stigmatizing language in speech and documentation.
- We describe behaviors and observations, not assumptions or labels.
- We avoid blame, judgment, and shaming, especially during moments of crisis.
- We include residents in conversations and decisions whenever possible.

Relationships drive outcomes
- Trust is foundational to safe and effective care.
- We meet residents where they are, not where we wish they were.
- We value lived experience as a form of expertise.

Safety is a shared responsibility
- We use routine screening to reduce stigma and support prevention.
- We monitor consistently for withdrawal and intoxication.
- We believe prevention and preparedness foster safety for everyone.

Person-centered care guides our work
- We align care plans with resident goals and readiness for change.
- When abstinence is not a resident's goal, we prioritize harm reduction and safety.
- We revisit goals and care plans as trust, health status, and needs evolve.

Equity and cultural humility are essential
- We acknowledge that AUD impacts individuals and communities differently.
- We recognize that everyone comes to us with a unique story, and that culture, life experiences, financial circumstances, and past trauma affect health and how care is received.
- We examine and address our implicit bias.
- We provide culturally responsive care based on what matters to the residents.

Staff well-being sustains care
- We acknowledge that caring for residents with alcohol use can bring up a lot of feelings.
- We normalize debriefs, reflection, and support after difficult events.
- We recognize staff wellness as essential to resident safety.

Our commitment
We commit to continuous learning, reflection, and collaboration. Through strong relationships, transparent processes, and shared values, we strive to create a rest home environment where residents and staff feel safe, respected, and supported.

Why now?

Alcohol is easy to access and is often seen as a regular part of life in our culture. Although legal, it is the most commonly misused substance in the world, which means people may not always recognize how harmful it can be to drink too much. Since the COVID-19 pandemic, more people have felt lonely, stressed, and anxious, which can lead to drinking more often. Many of us know someone affected by alcohol, and it can affect individuals, families, and communities. That is why it is important to show understanding instead of judgment. By being kind and caring, we can create a more supportive environment for everyone.

Why this toolkit?

Unhealthy drinking can be hard to notice. Rest home staff play an important role in spotting problems and helping residents get the support they need. With care and understanding, staff can help residents stay safe and learn healthier ways to cope.

Recognizing and addressing unhealthy alcohol use early can:

- Prevent falls, injuries, and problems with medications.
- Reduce trips to the hospital and readmissions.
- Improve quality of life and help residents stay involved in activities.

Resident impact: Finding and managing unhealthy alcohol use early helps residents stay healthier and enjoy a better quality of life. It also makes it easier to get help quickly and connect them with treatment when needed and/or wanted.

Staff empowerment: Staff are important in recognizing early signs of alcohol problems. This toolkit gives simple, clear support to help staff notice and respond to unhealthy alcohol use or AUD with care and respect for each resident.

What you will learn

- How alcohol use can affect residents and why noticing changes early helps keep everyone safe. Early awareness supports prevention, preparedness, and shared responsibility for safety.
- How to start respectful, trust-building conversations about alcohol use and use screening as a support—not a judgment. Relationships drive outcomes, and trust makes honest care planning possible.
- How using person-first, non-stigmatizing language protects resident dignity and staff dignity. Words matter, and dignity comes first in every interaction.
- How to support residents at different stages of readiness, including harm-reduction and safety-focused approaches. Person-centered care means meeting residents where they are while prioritizing safety.

Purpose & overview

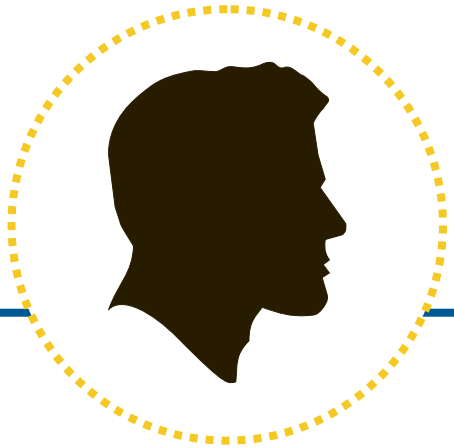
Every rest home supports residents whose relationship with alcohol is complicated. Some arrive with a long history of drinking. Some drink more after traumas - loss, illness, or isolation. Some drink for fun. Others never thought alcohol would become a health issue at all until it did. And sometimes it is not dementia, it is untreated AUD.

Staff often notice small changes first: missed meals, falls, confusion, and family tension. Too often, those signs are misunderstood, minimized, or addressed only after a crisis.

This toolkit exists to change that story. It will give rest home staff practical tools they need to recognize, manage, and support residents and their relationship with alcohol.

The resident journey through care

Meet three residents. These residents appear throughout the toolkit to illustrate how alcohol use and AUD care unfolds over time. See Appendix C for printable Residents' Stories.



Mr. James A.

Living with AUD and changing health status

Age: 72
History: High blood pressure, arthritis
Alcohol use: Drinks daily, usually in the evenings
Cognition: Intact
Change in Status (Early Signs)

Staff notice that Mr. A:

- Is more unsteady when walking
- Misses morning activities
- Has higher blood pressure readings

Mrs. Linda U.

Withdrawal, emergency response, and staff debrief

Age: 68
History: AUD, asthma, anxiety
Cognition: Forgetful

CNA: "Nurse, Mrs. U is shaking and seems confused. This is not how she usually is."
Nurse: "Thank you for telling me right away. Let's check her vitals."

Miss Kate D.

Living with AUD and changing health status

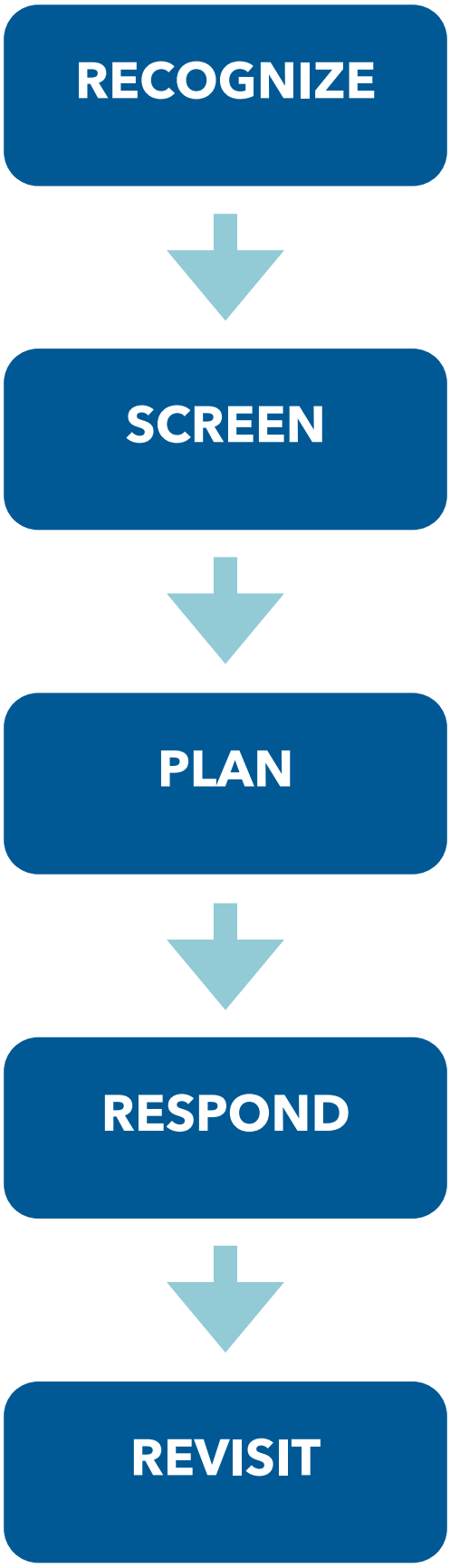
Age: 49
History: AUD, diabetes, complicated family history
Cognition: Intact

Family Dynamics:
Family Member: "You need to stop her from drinking."
Staff: "I hear your concern. Ms. D has the right to make her own choices, and we focus on safety."

- Family member demands staff "stop her from drinking."
- Brings alcohol despite concerns

Ms. D states:
"I'm an adult. I make my own choices."

These stories will remind us that care is not linear. It is shaped by trust, readiness, safety, and the systems that surround both residents and staff.


RECOGNIZE
SCREEN
PLAN
RESPOND
REVISIT

Stigma & bias

While understanding the physical and mental risks of alcohol use is important, it is also important to understand the social and emotional challenges that residents who use alcohol may face. Many residents experience stigma, which means negative judgments from others about their drinking. Stigma can make it harder for residents to get help, worsen their mental health, and change how they feel about themselves. Staff should be aware of stigma and bias so they can give kind, respectful care that supports residents' recovery and dignity.

Stigma means having negative ideas about someone because of something that makes them different, like having AUD, which can lead to discrimination. For example, a resident with AUD might feel ashamed of their drinking, and others might think it is their "personal failure." Stigma can make AUD worse because residents may believe these negative ideas, which can lead to sadness or change how they feel about themselves.

Unchecked stigma can lead to:

- Missed warning signs
- Increased falls
- Avoidable hospitalizations
- Mistrust between residents and staff, including hiding use
- Delayed or refused care
- Preventable injury or death

Stigma also affects staff. Fear of "saying the wrong thing," frustration with repeated behaviors, or moral distress when autonomy and safety collide can erode compassion and confidence.

Bias means favoring a certain group or idea, which can change how we think and make decisions.

Our biases come from our culture, what we learn from others, and our own experiences and beliefs.

Implicit bias occurs without our even noticing, because our brains are trying to quickly understand the world.

We can reduce bias by learning more, listening to different people, and treating everyone fairly.[1,2]

Staff stigma & bias exercise

Think of a time when a resident's alcohol use felt frustrating or concerning.
What assumptions may have shaped your response?

Step 1: Identity

Ask participants to privately write down three identities they hold.

These can be social, professional, relational, or personal roles.
Examples (participants choose their own):

Parent Sibling Veteran Teacher Caregiver Friend

Step 2: Mistakes

Next, ask participants to write down two things they have done wrong or regret in their life.

These should be:

- Non-traumatic
- Nothing overtly illegal
- Something they are comfortable acknowledging privately

Examples (for guidance only):

- Missed an important deadline
- Stole a pack of candy
- Made a poor decision
- Didn't show up for someone when they should have

Step 3: Remove an identity

Now instruct participants to cross out one of the three identities they listed.

Step 4: Promote the mistake

Next, ask participants to circle one of the mistakes and imagine it has now become the primary thing others associate with them.

Explain: "This mistake is now the first thing people know about you. It shows up in records, conversations, or assumptions before anything else."

Reflection questions

Invite participants to reflect silently or discuss (optional):

How did it feel to lose an identity that mattered to you?

How did it feel to have a mistake elevated above the rest of who you are?

What assumptions might others make about you based on that single detail?

How might this affect your access to trust, opportunity, or support?

Who experiences this kind of identity reduction most often in our systems?

Key takeaway

Stigma often forms when one action, diagnosis, or mistake is allowed to override a person's full identity. In health care, social services, and public systems, this can shape decisions, language, and outcomes often without conscious intent. This exercise isn't about guilt. It's about awareness. When we recognize how easily identity can be narrowed, we become more intentional about language, assumptions, and decisions, especially for people already facing stigma around their alcohol use.

How stigma acts as a barrier to getting help

Stigma is a major problem because residents may worry about how friends, family, or staff will treat them. Stigma can cause misunderstandings, lower the quality of care, and even lead to unfair treatment. Some people wrongly think addiction is a choice, which makes it harder to give good care. Research from Johns Hopkins University shows that people are often more negative toward someone with an addiction than toward someone with a mental illness.[3]

When working with residents who use alcohol, it is important to set aside your own experiences and not judge them. Focus on being kind and understanding. Remember that everyone's situation is different. Give each resident the care they need without letting your own feelings get in the way. This helps create a safe and respectful place where residents feel valued.

Reducing stigma

Stigma can be a large barrier to care and recovery for individuals with unhealthy alcohol use or AUD. Here are some ways to create a supportive and respectful environment:

- Treat all residents with dignity and respect. Every individual deserves compassionate and person-centered care.
- Build awareness among colleagues and residents that AUD is a diagnosed medical condition with effective, evidence-based treatments.
- Recognize that AUD is not a matter of "willpower" or personal failure. It is a complex health issue that can affect anyone.
- If you are in a leadership role, provide ongoing education for staff about unhealthy alcohol use, AUD, stigma, and bias.
- Encourage open conversations about stigma and its impact on care and recovery.
- Use non-stigmatizing language. Words have power; choose those that heal rather than harm.
- Avoid labels or blame. For example, replace terms like "alcoholic" with "person with an alcohol use disorder."

When we try to understand people rather than judge them, we create a kind and helpful place. This stops unfair ideas about others and helps residents feel seen, supported, and important as they work on getting better.[4]

Dignity is mutual

Resident dignity and staff dignity are deeply connected. When residents feel judged or dismissed, trust erodes. When staff feel unsupported or blamed, burnout and moral injury increase.

Humanizing alcohol use protects everyone in the care environment.

Leaders set the tone. When leadership openly names stigma and models person-centered language, staff feel safer practicing empathy and following best practices.

Words matter

Language shapes perception—and perception shapes care.

Understanding stigma and bias also means knowing how strong words can be. The words we use can unintentionally lead us to think unfairly about residents and to change how we care for them. Using old or mean words can make someone seem bad and affect how the next staff member treats them. All staff should use words that are kind, fair, and true. Notes should describe what you see, not guess or use labels.

Instead of labels, document:

- Observable behaviors
- Resident-reported experiences
- Safety concerns
- Care responses taken

Using respectful, non-stigmatizing language is not just about kindness; it is a safety strategy. Clear, neutral documentation:

- Improves team communication
- Reduces bias in decision-making
- Supports accurate care planning
- Builds resident trust over time

By choosing our words carefully, we can be kind, give better care, and show respect for everyone.

Additional Words to Use[5]

Alcohol Use Disorder (AUD)	**Unhealthy alcohol use**
Alcohol misuse	**Person with AUD**
Person in recovery	**Alcohol-associated liver disease**
Person in recovery from alcohol use disorder	**Alcohol-associated cirrhosis (or hepatitis, etc.)**

The resident journey - Mr. A

When staff described Mr. A.'s behavior using neutral, factual language rather than labels, care discussions stayed focused on safety and support. This consistency helped Mr. A. feel respected and more willing to engage.

Shared responsibility for culture change

Reducing stigma is not the responsibility of individual staff alone. It requires:

- Ongoing training
- Leadership modeling
- Clear policies
- Space for reflection and learning

Staff reflection

If another staff member reads your note, what picture of the resident would it create? Would it invite curiosity—or judgment?

What is one small language shift you could make today that might improve trust with residents?

Understanding alcohol use vs. alcohol use disorder

Definition

AUD is defined as alcohol use that causes symptoms affecting the body, thoughts, and behavior, and it is important to understand that it is a chronic medical condition diagnosed by a licensed provider. It affects how the brain and body work, making it hard to control or stop drinking. AUD can lead to physical, emotional, and social challenges. In 2024, 28 million people aged 12 years and older (or 1 in 10 people) had AUD in the United States.[6]

Symptoms of AUD

According to the definitive resource on mental health and substance use disorders, the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, (DSM-5-TR), AUD is diagnosed when a person has two or more symptoms within 12 months. Symptoms fall into three main areas:

Control over drinking	Impact over daily life	Physical addiction
Drinking more or longer than planned	Drinking even when it hurts your body or feelings	Needing more alcohol to feel the same effects (tolerance)
Trying to stop or cut down, not able to	Drinking even when it causes problems at home, work or school	Feeling sick, shaky, anxious, or nauseated when alcohol use is reduced or stopped (withdrawal)
Spending a lot of time drinking of feeling sick after drinking	Not being able to meet responsibilities because of drinking	
	Drinking in unsafe situations (e.g. driving)	

AUD ranges from mild to severe and can cause physical, emotional, and social problems. AUD can be mild, moderate, or severe, depending on how many symptoms someone is experiencing.[7]

Severity levels

Level	Number of symptoms	Example presentation
Mild	2-3	Social drinking is creeping into daily use; minor role disruption
Moderate	4-5	Relationship/work strain, withdrawal, increased tolerance
Severe	6+	Daily dependence, medical complications, social isolation

(DSM-5; American Psychiatric Association, 2013)

Alcohol use vs. alcohol use disorder

The difference between active alcohol use and AUD is that active alcohol use typically involves moderate consumption and does not lead to negative consequences such as legal issues, health problems, or significant impairment in daily life. Also, if someone who has moderate alcohol use decides to reduce or stop drinking and does not experience any withdrawal symptoms, then they do not have AUD.[8]

Risk of harmful drinking by residents

Drinking too much alcohol can cause serious health problems, including heart and liver disease, memory loss, mood changes, certain cancers, and a weakened immune system. As people age, their bodies change; they have less muscle and more body fat, which means alcohol stays in the system longer. ix As a result, they can feel the effects of alcohol more quickly, even when drinking smaller amounts. Older women are often more sensitive to these effects than older men.

Another concern is the interaction between alcohol and medications. Many older adults take several prescription drugs, and mixing them with alcohol can be dangerous or even life-threatening.

Older adults are at higher risk for alcohol-related harm because:

- They are more sensitive to alcohol's effects on balance, coordination, and attention, increasing the risk of falls and accidents.
- Alcohol can raise blood pressure and worsen conditions such as heart disease, diabetes, and breathing problems.
- Alcohol can interfere with how medications work or increase their side effects.
- Heavy or long-term drinking can speed up memory loss and increase the risk of dementia.[9]

Effects of alcohol on the body

Drinking too much can also hurt the brain and memory. Over time, it may lead to serious problems like alcohol-related dementia or Wernicke-Korsakoff syndrome, a brain problem that happens when the body doesn't have enough Vitamin B1. Drinking a lot at once can cause blackouts, falls, and make someone act in ways that are unsafe or hurtful to themselves or others.[10, 11]

Key points

Alcohol can harm thinking, memory, and decision-making over time.
Drinking a lot or too quickly can cause blackouts, falls, and injuries.
Long-term alcohol use can make other health problems worse and make accidents more likely.

Additional information: Addressing Alcohol Use in Nursing Facilities

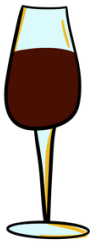
What counts as "one drink"?

One standard drink means:

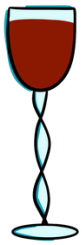
- 12 ounces of regular beer (1 can)
- 5 ounces of wine (1 small glass)
- 1.5 ounces of liquor (1 shot)

Tip: Bigger pours or mixed drinks may count as more than one drink.

12 oz of regular beer (1 can)

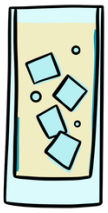


5 oz of table wine



2-3 oz of cordial, liqueur or apertif

1.5 oz of brandy or cognac (a single jigger)



8-10 oz of malt liquor or hard seltzer

1.5 oz of distilled spirits (gin, rum, tequila, vodka, whiskey, etc.

When does drinking become a problem?

Drinking becomes concerning when it:

- Interferes with daily activities, relationships, or health.
- Leads to repeated falls, confusion, or medication interactions.
- Causes withdrawal symptoms when alcohol use stops.
- Impacts mood, sleep, or nutrition.
- Requires increasing amounts to feel the same effect.

Conversations that build trust

Screening as a safety practice and assessment tools

Screening for harmful alcohol use is a standard safety practice and a critical opportunity to build trust. When done consistently and respectfully, it reduces stigma and supports honest disclosure. See Appendix D for Screening and Response Decision Tree.

Staff should explain screening clearly and normalize the process:

- Screening happens for everyone
- Screening is about safety, not punishment
- Residents remain in control of what they share

Screening should be:

- Private so residents feel safe.
- Nonjudgmental: "We screen everyone to make sure we can give them the support they need."
- Completed when a resident first arrives at your rest home or long-term care facility.
- Done for each resident at least once a year.
- Completed anytime there are changes in behavior or health.
- Completed following a big life change or traumatic event.

Staff reflection

How you introduce screening can shape the entire care relationship. What words help residents feel safe rather than judged?

Why screen?

Screening results guide conversation—not conclusions. Think of screening as the beginning of a pathway:

Asking simple, evidence-based questions can help determine whether a resident's drinking is causing problems. Screening is not a diagnosis; it only shows if further assessment or support is needed. Finding issues early helps prevent health problems and connects residents to the proper care.

Many residents drink for reasons like loneliness, pain, or trouble sleeping. But alcohol can make these problems worse and cause serious health risks.

Recommended screening tools:

AUDIT-C (3 questions): a short questionnaire about drinking habits

- How often did you have a drink containing alcohol in the past year?
- On days in the past year when you drank alcohol how many drinks did you typically drink?
- How often did you have 6 or more (for men) or 4 or more (for women and everyone 65 and older) drinks on an occasion in the past year?

If this tool doesn't feel right for your facility, see Appendix E-H for more evidence-based options.

Motivational interviewing

Motivational interviewing is a way of talking with residents that helps them think about change at their own pace. The goal is not to tell residents what to do, but to listen, show respect, and support their decisions.

Staff use motivational interviewing to:

- Ask open and honest questions
- Listen without judging
- Respect the residents' choices
- Help residents explore whether they want to cut down, quit, or keep things the same
- Residents are more likely to engage in treatment when they feel heard and in control of their decisions.

These conversations help staff build trust and create care plans that match the residents' goals and readiness for change.

Talking with a resident about alcohol use

A resident drinks alcohol most evenings. Staff want to check in and understand the residents' thoughts about their drinking.

Example 1: Motivational Interviewing: Correct Approach

Staff: "Would it be okay if we talked for a few minutes about your drinking?"
Resident: "I guess so."
Staff: "Thanks. How do you feel about your drinking right now?"
Resident: "I don't think it's a big problem, but I do feel tired in the mornings."
Staff: "It sounds like drinking helps you relax, but being tired is hard for you."
Resident: "Yeah, I don't like feeling tired."
Staff: "What do you think might help you feel better in the mornings?"
Resident: "Maybe cutting back a little."
Staff: "That makes sense. If you would like, we can talk about some options and support that are available."

Why this works:

- The staff listens
- The resident leads the descision
- No pressure of judgement

Example 2: Not Motivational Interviewing: What to avoid

Staff: "You really shouldn't be drinking. It's bad for your health."
Resident: "I've been drinking this way for years."
Staff: "Well, you need to stop, or you'll get worse."
Resident: "I don't want to talk about this."

Why this does not work:

- The staff tells the resident what to do
- The resident feels judged
- The conversation shuts down

Documentation and privacy:

Staff should document results carefully and keep information private, sharing only with the care team.

- Record findings in the resident's clinical record.
- Maintain confidentiality under HIPAA and 42 CFR Part 2.
- Share information only with staff directly involved in care.

The resident journey - Mr. A

Staff noticed that Mr. A was unsteady when walking, was missing morning activities, and had higher blood pressure readings. To find out what may be going on with Mr. A, a care provider had a screening conversation with him (1 on 1).

Screening and conversation

A nurse uses a brief alcohol screening tool and follows up with a motivational interviewing (MI) conversation.

Example dialogue

I"I have noticed you have seemed more tired lately. Would it be okay if we talked about how alcohol fits into your day?"
Mr. A shares that drinking helps him relax, but admits he has been feeling weaker.
"What do you enjoy about drinking? And what are some things you don't enjoy as much?"
How often did you have a drink containing alcohol in the past year?
On days in the past year when you drank alcohol, how many drinks did you typically drink?
How often did you have 4 or more drinks on an occasion in the past year?

Staff reflection:

- What signs made you pause and check in?
- Did the staff ask for permission?
- Did the staff avoid judgment or assumptions?
- How would you document this observation?

Care planning

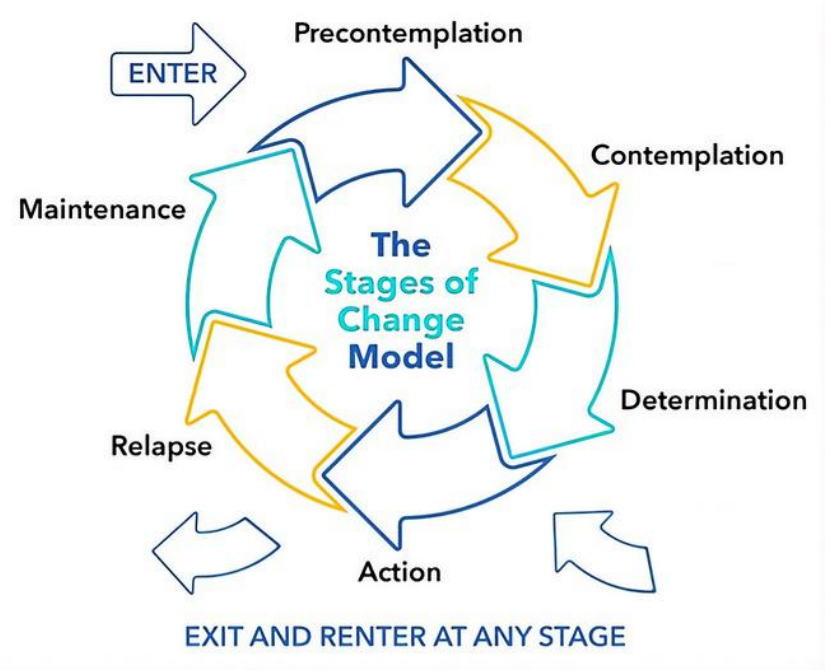
Incorporating readiness for change

As we move from screening to care planning, it is important to remember that stigma and bias can affect how people feel about seeking help. When care plans are respectful and person-centered, they can help remove these barriers. Care planning works best when residents feel heard and respected. Plans should reflect:

- The resident's goals
- Their readiness for change
- Immediate safety needs
- Opportunities for harm reduction

When developing or updating a care plan, consider the residents' readiness to change their alcohol use. The Stages of Change Model (Prochaska & DiClemente) offers a framework for understanding where a resident is on their recovery journey.[12]

Residents may move forward and backward through stages, and staff support is most effective when it aligns with the resident's current stage.



Meet residents where they are, whether they are just starting to consider change or continuing to build new habits. Matching interventions to readiness helps residents feel understood and supported.

- Precontemplation: Focus on building trust and awareness while avoiding confrontation.
- Contemplation: Provide education and discuss the pros and cons of change.
- Preparation: Support goal setting and connecting resources.
- Action: Reinforce progress and coping strategies.
- Maintenance: Encourage ongoing support and relapse prevention.
- Relapse (return to use): Respond with empathy and re-engage support without judgment.
  - It starts with the Precontemplation stage, where they might not see their drinking as a problem.
  - Then, in the Contemplation and Determination stages, they begin to recognize the problem and plan for change.
  - The Action stage is when they actively work on stopping or reducing alcohol use.
  - In the Maintenance stage, residents will try to keep their progress and avoid setbacks (relapses). This model helps us understand and support residents at each step of their recovery journey.

Staff reflection

Think of a resident who drinks alcohol regularly. Which stage best describes them today? What would "next step" support look like?

When a resident is not ready to change their drinking, how can care planning still promote dignity and safety?

Resident journey: Mr. A.

Mr. A. did not initially see his drinking as a problem. Because the staff approached screening as routine and respectful, trust developed.

Harm reduction

Staff: "It sounds like you're not ready to stop drinking, and that's okay. Would you be open to a few ideas to help keep you safe?"
Mr. A: "Yeah, I could try a couple things."

Mr. A is not ready to stop drinking, but agrees to:

- Drink earlier in the day
- Limit the number of drinks
- Eat before drinking
- Accept fall-risk support

Reflection

Did staff respect the residents' choices?
What harm-reduction options were offered?
How can staff follow up without pressure?

Treatment

Treatment is not a single decision point. It is an evolving process shaped by trust, readiness, and safety.
Residents may:

- Want to stop drinking alcohol
- Want to reduce use
- Not want to change at all
- Each position deserves a response rooted in respect and safety.

Motivational interviewing, harm-reduction strategies, and regular re-screening help ensure that care plans remain aligned with residents' goals.

- After screening: Use the residents' responses to guide next steps.
- During care planning: Match the goals to what the resident is ready for, and do not push treatment before they are ready.
- If they are ready: Help the resident get ready to speak with their supports and find the right kind of treatment (e.g., Medication for Addiction Treatment (MAT), counseling, or support groups).
- Throughout: Encourage regular communication, involve family if it is okay, and follow up on screenings to check progress.

Not every resident will be ready to change. Your role is to assess and maintain a supportive, stigma-free environment that helps residents move at their own pace, meeting them where they are at, while prioritizing health and safety.

Resident journey: Mr. A.

Over time, Mr. A. shared more openly, allowing staff to adjust his care plan to reduce fall risk and support safety—even before he was ready for change.

Care plan update

Staff: "We will write down what matters to you so everyone on the team supports the same plan."
The care plan includes:

- Monitoring vital signs
- Medication review
- Ongoing conversations
- Clear documentation of resident goals
- Care plans support safety and quality of life, not punishment.

Reflection

Does the care plan reflect the resident's goals?
Is the language respectful?
Is the plan realistic?

Staff reflection

What does "success" look like when abstinence is not the goal? How do we measure safety, trust, and engagement?

Withdrawal and safety considerations

Withdrawal is not a behavioral condition; it is a medical condition. When a resident with AUD cuts down or stops drinking, they may go through withdrawal. Withdrawal can be mild, but it can also become serious or even life-threatening. The resident may feel the need to drink to relieve or avoid such symptoms. That is why it is important for staff to notice symptoms early and keep residents safe. See Appendix I for a Symptom Checklist.

Common alcohol withdrawal symptoms

Withdrawal can start a few hours to a few days after stopping alcohol. According to the DSM-5, a person may be experiencing alcohol withdrawal when two or more of the following symptoms happen:

- Sweating or fast heartbeat
- Shaking hands
- Trouble sleeping
- Nausea or vomiting
- Seeing, hearing, or feeling things that aren't real
- Feeling worried or nervous
- Feeling upset, restless, or unable to sit still
- Seizures (shaking or jerking that cannot be controlled)

Keeping residents safe

- Withdrawal can get worse quickly.
- Spotting symptoms early helps staff monitor residents safely and get medical help if needed.
- Checking for withdrawal risk helps staff make a safe care plan.

What should staff do?

- Watch for two or more withdrawal symptoms.
- Tell a nurse or medical provider right away.
- Follow care plans for monitoring and safety.
- Make sure the resident's environment is safe while symptoms are being watched.

Overdose or alcohol poisoning prevention

Educate staff on recognizing signs of overdose or alcohol poisoning, and protocols for emergency response are clearly posted and practiced. Include naloxone training when appropriate. See Appendix J for Overdose Decision Tree.

Key guidelines[13,14]

- Confusion, irregular breathing, or blue skin → Call 911 immediately.
- Do not leave the resident alone or try to induce vomiting.
- Do rescue breathing if the person is not breathing.
- Use the recovery position while awaiting medical help.
- Administer naloxone if opioids may be involved.

Signs of alcohol poisoning

- Confusion or unresponsiveness
- Slow or irregular breathing (<8/min)
- Blue or pale skin
- Seizures
- Vomiting while unconscious

Emergency response steps when a resident is potentially experiencing alcohol poisoning

1. Check responsiveness – gently shake and shout.
2. Call emergency services.
3. Position in the recovery pose (on side, head tilted).
4. Monitor breathing until help arrives.
5. Rescue breathing if the person is not breathing
6. Do not leave alone or try to "sleep it off."
7. Administer naloxone if opioid use is suspected.

Preventive measures

Encourage drinking in moderation or abstinence from binge drinking.
Educate residents on interactions with meds.

Community-based supports

Recovery organizations

Online and community-based groups can be helpful during alcohol withdrawal, active treatment and long-term support from others who have similar lived experiences. See Appendix K. for more information on these organizations.

SMART Recovery is the leading, evidence-informed approach to overcoming addictive behaviors and leading a balanced life. To find online or in-person meetings nearby, start here: Find a meeting

Alcoholics Anonymous (AA) is a fellowship of people who come together to share their experience with AUD and receive support from others who understand. AA works as a 12 step program.
Find a meeting
Meeting finder app
212-870-3400

Life Ring Secular Recovery provides abstinence-based, secular, and self-directed recovery pathways through meetings and support communities. Learn more and find meetings here: Find a meeting
800-811-4142

Groups for family members

Families Anonymous (FA) provides fellowship for the family and friends of those individuals with alcohol or substance use disorder. Meeting directory: Find a meeting

Al-Anon is a mutual support program for people who have a family member or friend with AUD. Learn more and find a meeting here: Find a meeting

Other support groups for different conditions that may be co-occurring with AUD:

- Narcotics Anonymous
- Gamblers Anonymous

Massachusetts resources

Massachusetts Substance Use Helpline:
English Website; Spanish Website or call to speak with a specialist.

Bureau of Substance Addiction Services (BSAS) within the Department of Public Health (617) 624-5111

Community Behavioral Health Centers (CBHCs)

Aging Services Access Points (ASAPs)

Massachusetts Older Adult Behavioral Health Network

Veterans' Services

National Alliance on Mental Illness, MA Chapter (NAMI MA)
The Compass Helpline

National resources

988 Lifeline

Professional Associations of Medical and Nonmedical Addiction Specialists

- American Academy of Addiction Psychiatry | 401-524-3076
- American Psychological Association | 1-800-374-2721

(Ask for your state's referral number to find psychologists with addiction specialties.)

- American Society of Addiction Medicine | 301-656-3920

Treatment Finders
NIAAA Alcohol Treatment Navigator®—How to Find Quality Alcohol Treatment

SAMHSA's Behavioral Health Treatment Services Locator
1-800-662-HELP (4357)

Treatments

Psychosocial treatments

Behavioral therapies for AUD help residents change behaviors, develop healthy coping strategies, and improve their motivation and support systems.

- Motivational Interviewing (MI)
- Cognitive Behavioral Therapy (CBT) with a mental health professional
- Peer support groups (AA, SMART Recovery, Women for Sobriety, etc.)
- Cultural or faith-based support
- Structured activities to reduce isolation

Medication for Addiction Treatment (MAT) for AUD

Medication-Assisted Treatment, or MAT, is when a doctor or other licensed independent providers prescribe medication to help residents with AUD. These medicines can:

- Reduce cravings
- Make it easier to cut down or stop drinking
- Support long-term recovery

MAT is safe, backed by science, and must be prescribed by a licensed medical provider. It works best when used along with counseling, support, and a clear care plan.

MAT is not the same for everyone. A provider will choose the medicine that is safest and most helpful based on the residents' health history, needs, and goals. The resident is responsible for managing their MAT, but you can provide reminders and look out for changes in behavior or mental status.

View a list of medications used for AUD here:
Appendix L: Medication Chart

Resident journey - Mrs. U.

Post-event care planning

After hospitalization, Mrs. B returns with:

- Medication for withdrawal prevention
- Clear orders related to alcohol use

The care team:

- Updates the care plan
- Communicate with all shifts
- Has an open and honest conversation using MI as a tool to discuss safety going forward

Reflection

- How can staff prevent sudden withdrawal?
- Is the care plan clearly communicated to all shifts?
- How do we reduce future risk?

Staff debrief

Leadership holds a staff debrief:

- What went well?
- What was stressful?
- What can we improve next time?
- How did this situation affect staff emotionally?

Family & community

Supporting residents with unhealthy alcohol use and those with AUD does not stop at the walls of the rest home. Families, caregivers, and community programs play a vital role in helping residents maintain health, safety, and recovery. Families and caregivers can be powerful allies in supporting residents.

They often hold important history, insight, and concern for their loved one's safety and well-being. At the same time, family involvement must always be guided by resident consent, clear boundaries, and shared expectations.

Effective family engagement:

- Centers the residents' goals and preferences
- Respects privacy and consent
- Sets clear roles and boundaries
- Focuses on safety and dignity; not control

Staff reflection

How do you balance family concern with a resident's right to autonomy and privacy?

Resident journey - Ms. D

Family dynamics

Ms. D's family: "You need to stop her from drinking."
Staff: "I hear your concern. Ms. D has the right to make her own choices, and we focus on safety."

Ms. D's family demands staff "stop her from drinking" and brings alcohol despite concerns

Ms. D states: "I am an adult. I make my own choices."

Staff maintained empathy for the family's concern while honoring Ms. D's goals. Leadership supported consistent messaging and clarified policy, reducing conflict and supporting trust on all sides.

Staff response and conversation

Staff: "What feels helpful from your family, and what feels stressful?"
Ms. D.: "I want support, not control."

Staff ask follow up questions with Ms. D. to explore:

- Her goals
- What feels supportive vs. controlling

Staff also communicate clearly with family about:

- What the rest home can and cannot do
- Respecting resident autonomy

Staff reflection

- How do staff balance family concerns and resident rights?
- What language keeps the conversation calm?
- When should leadership be involved?

Leadership and stakeholder engagement

Administrator: "We want to support everyone while respecting Ms. D's rights and safety."

Leadership steps in to:

- Support staff
- Align messaging across the team
- Meet with family using a calm, consistent approach

Providing information on family involvement, local support services, and community resources complements care within the facility and helps residents thrive after discharge. No rest home can support residents on its own. Strong partnerships extend care beyond the facility and improve continuity and outcomes.

Prioritize partnerships with organizations that share your rest home's values:

- Person-centered care
- Harm reduction
- Equity and cultural humility
- Trauma-informed practice

These partnerships may include:

- Treatment providers
- Recovery and peer-support organizations
- Harm reduction services
- Culturally specific community groups
- Senior centers

Staff reflection

Which community partners feel aligned with your rest home? Where might stronger relationships improve resident care?

You can find more helpful information and resources in the appendices at the end of this toolkit.

Staff supports

Staff training

Building confidence and consistency in how staff respond is important for supporting residents. It is about being kind, keeping people safe, and working as a team. This approach helps staff learn how to understand, talk with, and support residents using proven, trauma-informed, and caring methods. See Appendix M for Checklist.

It moves from:

Learning Information → **Building Positive Attitudes** → **Practicing Skills** → **Making Care Plans**

all to create a safe place without stigma.

Training on this content should happen regularly:

- Orientation/Onboarding: Introduction to key concepts, resident care standards, and stigma-free communication.
- In-Service Trainings: Offered quarterly or biannually to reinforce best practices, introduce updates in evidence-based care, and allow staff to reflect on real-life experiences.
- Annual Training: This training helps staff build their skills, stay consistent, and support a caring and responsible approach to helping residents.

These ongoing trainings help provide all team members, new and experienced, with the knowledge, confidence, and compassion necessary to provide high-quality, person-centered care to residents with AUD.

Scenario-based training allows staff to practice empathy, safety, and communication in realistic situations.

List of trainings

Staff wellness, compassion fatigue & boundaries

Why staff wellness is a safety issue

Supporting residents who have a complex relationship with alcohol requires emotional labor, vigilance, and sustained empathy. When staff well-being is overlooked, the risk of burnout, compassion fatigue, and moral injury increases—directly impacting resident safety and quality of care.

Staff wellness is not optional. It is foundational to safe, consistent, and dignified care.[15,16]

Understanding compassion fatigue

Signs:

- Irritability or numbness
- Trouble sleeping
- Avoiding certain residents
- Loss of empathy

Self-care strategies

- Take scheduled breaks during shifts
- Peer debriefs after difficult events
- Engage in exercise, rest, and hobbies
- Use employee assistance programs or counseling support

Staff reflection

When you feel exhausted or overwhelmed, how does it show up in your interactions with residents?

Team culture

Promote:

- "No blame" supervision
- Regular reflection circles
- Recognition of emotional work

Boundaries:

- Avoid over-identification with residents
- Maintain professional limits
- Seek help early for emotional strain

Staff reflection

Which signs of compassion fatigue feel most familiar to you? What support helps most when you notice them?

Leadership's role in wellness

Leaders are responsible for creating conditions where staff can do their best work.
This includes:

- Normalizing debriefs after difficult events
- Providing regular training and refreshers
- Encouraging use of support resources
- Modeling healthy boundaries

Leadership lens

How do leaders signal that staff well-being matters—not just outcomes?

Leadership practices

Why leadership matters

Leaders shape the culture of care in rest homes. When leaders model respect, compassion, and accountability, staff follow that example. This builds a safe, supportive environment where residents who use alcohol can heal and thrive.

Key leadership actions

1. Build a person-centered culture

- Review and update mission and vision statements to include person-centered care.
- Show that you value residents' voices by involving them and their families in decision-making.
- Encourage use of person-first language (e.g., "person with AUD" instead of "alcoholic").

1. Create supportive policies

- Develop clear policies that:
  - Prohibit discrimination against residents who use alcohol or have AUD.
  - Include trauma-informed care and harm-reduction principles.
  - Ensure naloxone is available and safely stored.
- Form a Resident & Family Advisory Council to guide improvement.
- Integrate culturally and linguistically appropriate services (CLAS).

1. **Provide staff education**

Train all staff, clinical and non-clinical, on:

- Understanding AUD as a medical condition.
- Reducing stigma/bias and supporting recovery.
- Common triggers for AUD
- Social identities in AUD
- Harm reduction
- Recognizing signs of withdrawal and responding safely.
- Preventing and responding to overdose.
- Trauma-informed care and de-escalation skills.
- Refresh training regularly.

Resident journey: Ms. D.

Ms. C's case reveals gaps in current policy.

- Alcohol storage
- Resident and family education
- Staff de-escalation pathways

Leadership updates policies and provides staff training as a follow-up to this case. Strong policies protect residents, staff, and families.

Tools for leaders

Engage residents and families

- Use strategies such as authentic membership, full participation, and meaningful contributions when developing policies.

Measure progress

- Use self-assessments and quality improvement tools to check if person-centered care is being carried out.
- Collect feedback from staff, residents, and families.

Create a safe environment

- Limit harmful substances by setting fair visitor policies.
- Keep strong chain-of-custody systems for medications.
- Promote respectful communication at all levels.

Quick visual reminders

See Appendix N, for Rest Home Policy Sample

Scenario-based knowledge check

Leadership & culture of care

Ms. D. Over the past month, staff have reported increased tension related to alcohol storage, visitor interactions, and how to de-escalate situations when Ms. D. becomes upset. Some staff refer to her as "difficult" and express frustration. Family members report confusion about facility expectations and policies.

A staff member refers to Ms. D. as "an alcoholic who won't follow the rules" during a meeting.

Knowledge check:
- **How should a leader respond in the moment?**
- **What message does the leader's response send to staff about respect, stigma, and expectations?**

Current policies do not clearly address alcohol storage, harm reduction, or staff response pathways.

Knowledge check:
- **What policy areas should be reviewed or updated based on this scenario?**
- **How can policies balance safety, dignity, and non-discrimination?**

During an interaction, Ms. D. becomes visibly distressed and raises her voice.

Knowledge check:
- **What trauma-informed and de-escalation practices should guide staff response?**
- **How can leadership reinforce these principles are consistently applied?**

Takeaway for leaders:

Person-centered care is about seeing the whole person, not just the condition. By modeling empathy, setting fair policies, educating staff, and partnering with residents and families, leaders can create a culture where recovery and dignity are always possible.

Leadership lens:

How does your organization invite feedback and adapt when current practices are no longer serving residents or staff?

Closing reflections & calls to action

Caring for residents with AUD is complex, deeply human work. It requires an understanding of health care, emotional presence, clear systems, and above all relationships built on trust and dignity.

This toolkit is not intended to be static. It is a living guide that reflects evolving best practices, resident needs, and staff experience. Progress happens not through perfection, but through reflection, consistency, and willingness to learn.

A final reflection for staff

Every interaction matters. Small moments tone of voice, word choice, follow through can either build trust or reinforce harm.

Staff reflection

Think about a recent interaction that felt challenging. What helped maintain dignity? What would you want to try differently next time?

For all staff:

- Keep learning and asking questions
- Use respectful, person-first language
- Practice reflection individually and as a team
- Remember that relationship-building is part of the work, not separate from it

For leaders and supervisors:

- Model the values outlined in this toolkit
- Name and address stigma when it appears
- Support staff through training, debriefs, and supervision
- Ensure policies support dignity, safety, and consistency

For organizations and systems:

- Engage residents and families/caregivers as partners in improvement
- Build and sustain value-aligned community partnerships
- Review incidents and outcomes with a learning mindset
- Remain open to change as evidence and best practices evolve

A hopeful close

Safety, dignity, and recovery are possible—even when change is slow or uneven. When rest homes commit to person-centered care, clear systems, and shared responsibility, both residents and staff are better supported.

Progress happens one conversation, one decision, and one relationship at a time.

Appendices

Appendices include screening tools (AUDIT-C, CAGE-AID), sample care plans, resident education handouts, staff quick reference sheets, and sample policies

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Rest home staff quick reference alcohol & substance use policies

Appendix A

1. Screening & documentation
   - Screen all residents at: admission, annually, and when behavior/health changes
   - Approved tools: AUDIT-C, CAGE-AID, TAPS, SBIRT

   Document:
   - Tool & score
   - Observations & resident statements
   - Actions taken (monitoring, referral, interventions)
   - Keep records confidential
   - Report positive screens to licensed provider for evaluation

2. Alcohol on grounds
   - Alcohol allowed only with assessment & provider approval
   - Store alcohol securely
   - Document: amount, time, observed effects
   - Not allowed for residents at unsafe use risk, on contraindicated meds, or medical restrictions

3. Managing intoxication or withdrawal
   - Recognize intoxication: slurred speech, unsteady gait, confusion, odor
   - Recognize withdrawal: sweating, tremors, nausea, agitation, anxiety, hallucinations, seizures
   - Immediate actions:
     - Ensure resident safety
     - Notify licensed provider immediately
     - Follow care plan & monitoring protocols
     - Never leave resident alone if at risk
   - Medical emergency: seizures, hallucinations, or respiratory compromise → call EMS

4. Staff cCommunication & privacy
   - Use non-stigmatizing, person-centered language
   - Share information only with authorized staff, providers, and family (if appropriate)
   - Documentation must be accurate, timely, and secure (HIPAA compliant)
   - Model supportive, respectful communication; avoid judgment

Quick tips
   - Always treat suspected overdose or withdrawal as a medical emergency
   - Keep protocols visible at nursing stations
   - Regular staff training improves safety and care consistency
   - Document every intervention and observation to inform ongoing care

Values statements

Appendix B

As staff members at _____ , this statement reflects our commitment to safe, compassionate, and equitable care for residents with Alcohol Use Disorder (AUD) and active alcohol use. It is intended to guide daily practice, decision-making, and leadership actions across all roles.

Dignity comes first
- We recognize AUD as a health condition, not a moral failing.
- We treat every resident with respect, compassion, and humanity.
- We honor resident autonomy while prioritizing safety.
- We recognize that staff dignity and resident dignity are inseparable.

Words matter
- We use person-first, non-stigmatizing language in speech and documentation.
- We describe behaviors and observations, not assumptions or labels.
- We avoid blame, judgment, and shaming, especially during moments of crisis.
- We include residents in conversations and decisions whenever possible.

Relationships drive outcomes
- Trust is foundational to safe and effective care.
- We meet residents where they are, not where we wish they were.
- We value lived experience as a form of expertise.

Safety is a shared responsibility
- We use routine screening to reduce stigma and support prevention.
- We monitor consistently for withdrawal and intoxication.
- We believe prevention and preparedness foster safety for everyone.

Person-centered care guides our work
- We align care plans with resident goals and readiness for change.
- When abstinence is not a resident's goal, we prioritize harm reduction and safety.
- We revisit goals and care plans as trust, health status, and needs evolve.

Equity and cultural humility are essential
- We acknowledge that AUD impacts individuals and communities differently.
- We recognize that everyone comes to us with a unique story, and that culture, life experiences, financial circumstances, and past trauma affect health and how care is received.
- We examine and address our implicit bias.
- We provide culturally responsive care based on what matters to the residents.

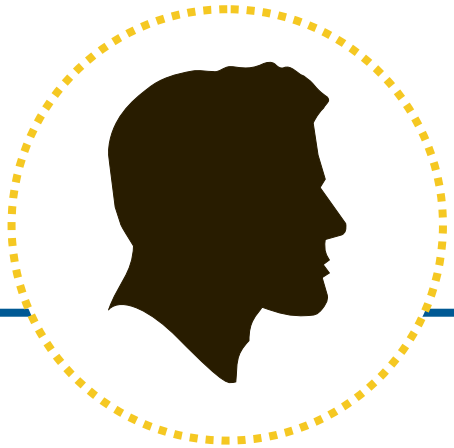
Staff well-being sustains care
- We acknowledge that caring for residents with alcohol use can bring up a lot of feelings.
- We normalize debriefs, reflection, and support after difficult events.
- We recognize staff wellness as essential to resident safety.

Our commitment
We commit to continuous learning, reflection, and collaboration. Through strong relationships, transparent processes, and shared values, we strive to create a rest home environment where residents and staff feel safe, respected, and supported.

Meet the residents

Appendix C

Meet three residents. These residents appear throughout the toolkit to illustrate how alcohol use and AUD care unfolds over time. See Appendix C for printable Residents' Stories.



Mr. James A.

Living with AUD and changing health status

Age: 72
History: High blood pressure, arthritis
Alcohol use: Drinks daily, usually in the evenings
Cognition: Intact
Change in Status (Early Signs)

Staff notice that Mr. S:

- Is more unsteady when walking
- Misses morning activities
- Has higher blood pressure readings

Mrs. Linda U.

Withdrawal, emergency response, and staff debrief

Age: 68
History: AUD, asthma, anxiety
Cognition: Forgetful

CNA: "Nurse, Mrs. U is shaking and seems confused. This is not how she usually is."
Nurse: "Thank you for telling me right away. Let's check her vitals."

Miss Kate D.

Living with AUD and changing health status

Age: 49
History: AUD, diabetes, complicated family history
Cognition: Intact

Family dynamics:
Family member: "You need to stop her from drinking."
Staff: "I hear your concern. Ms. D has the right to make her own choices, and we focus on safety."

- Family member demands staff "stop her from drinking."
- Brings alcohol despite concerns

Ms. D states:
"I'm an adult. I make my own choices."

These stories will remind us that care is not linear. It is shaped by trust, readiness, safety, and the systems that surround both residents and staff.

Alcohol use screening & response checklist

Appendix D

Step 1: Start with screening

Screen everyone to support safety - not to judge
Use AUDIT-C or CAGE-AID:

- At admission
- At least once a year
- Any time behavior, mood, or health changes
- After falls, medication issues, or unexplained confusion

Did the resident screen positive or raise concerns?

NO
Continue routine care and rescreen later

YES
Go to Step 2

Step 2: Check immediate safety

Look first for risk.
Check for:

- Intoxication (unsteady walking, slurred speech, confusion, odor of alcohol)
- Withdrawal (shaking, sweating, nausea, anxiety, seizures, hallucinations)

Is there an immediate safety concern?

YES
Notify nurse/provider right away

NO
Go to Step 3

Step 3: Talk and listen

Use respectful, non-judgmental language, document what the resident shares, and maintain privacy.

Say:
"We ask everyone this to help keep them safe."

Ask:
"How often do you drink alcohol?"
"Has your drinking changed recently?"
"Has alcohol ever caused problems for you?"

Then ask yourself:
Is the resident ready to make a change right now?

Alcohol use screening & response checklist

Appendix D

PATH A: Resident ready for change

What this looks like
Resident says they want to cut back or stop
Expresses concern about health, falls, sleep, or safety

Staff actions
✓ Notify provider
- Share screening results
- Observed symptoms
- Residents' comments
- Safety Concerns

✓ Update care plan with resident input
- Safety precautions (falls, monitoring, medication interactions)
- Withdrawal monitoring if ordered
- Harm-reduction strategies (safety & health support, reducing withdrawal risks)
- Resident preferences, goals, and supports
- Family involvement (as appropriate)

✓ Support treatment choices (counseling, medication, groups)
✓ Follow up regularly

Staff say
"What kind of support would help you?"
"We can take this one step at a time."

Provider actions
- Determine next steps:
- Possible AUD diagnosis
- Orders for withdrawal monitoring
- Medication considerations
- Referral to treatment

Success = Safety + resident-led goals + trust

Alcohol use screening & response checklist

Appendix D

PATH B: resident *not ready* for change

What this looks like
Resident does not want to change drinking
Says "I'm fine" or "I'm not ready"

Staff actions
✓ Respect the resident's choice
✓ Focus on harm reduction and safety
✓ Update care plan with safety supports
✓ Monitor for changes
✓ Revisit the conversation later
✓ Practice harm reduction strategies

Staff say
"You're in charge of your choices."
"Let's talk about how to keep you safe."

Success = Dignity protected + risks reduced + relationship intact

Step 4: Document & follow up

Describe what you see – not labels

Document:
- What the resident shared
- Safety concerns
- Agreed-upon plans
- Follow-up needs
- Re-screen if health, mood, or behavior changes

Remember

You are not here to force change.
You are here to build safety, trust, and support wherever the resident is right now.

AUDIT-C

Appendix E

Purpose:

Fast screen for risky drinking or possible Alcohol Use Disorder

Questions (score each 0–4):

How often do you have a drink containing alcohol? Score: ___

How many standard drinks do you have on a typical day? Score: ___

How often do you have 6 or more drinks on one occasion? Score: ___

Interpretation:

Men: ≥4 = positive screen

Women & older adults: ≥3 = positive screen

Reference:

Bush K, Kivlahan DR, McDonell MB, Fihn SD, Bradley KA. The AUDIT alcohol consumption questions (AUDIT-C): an effective brief screening test for problem drinking. Ambulatory Care Quality Improvement Project (ACQUIP). Alcohol Use Disorders Identification Test. Arch Intern Med. 1998 Sep 14;158(16):1789-95. doi: 10.1001/archinte.158.16.1789. PMID: 9738608.

CAGE-AID

Appendix F

Purpose:

Screen for alcohol or drug misuse. Yes = 1 point, No = 0 points.

- Have you ever felt you should cut down on your drinking or drug use?
- Have people annoyed you by criticizing your drinking or drug use?
- Have you ever felt guilty about your drinking or drug use?
- Have you ever needed a drink or drugs first thing in the morning (Eye-opener)?

Score: ___ / 4

Interpretation: Score ≥2 = clinically significant and suggests a high likelihood of an AUD and/or alcohol dependency.

Reference:

Brown RL, Rounds LA. Conjoint screening questionnaires for alcohol and other drug abuse: criterion validity in a primary care practice. Wis Med J. 1995;94(3):135-40. PMID: 7778330.

CAGE Questionnaire Assessment

SBIRT

Appendix G

SBIRT (Screening, Brief Intervention, and Referral to Treatment)

Purpose:

SBIRT is an evidence-based framework for identifying, reducing, and preventing risky alcohol and substance use.

SBIRT components:

Screening

- Identify risky alcohol or substance use early
- Use validated screening tools (AUDIT-C, CAGE-AID, TAPS)

Brief Intervention

- Short, structured conversation
- Uses motivational and person-centered language
- Focuses on safety, awareness, and resident goals

Referral to Treatment

- Connect residents to specialized care when indicated
- Includes medical, behavioral health, or substance use treatment

When to Use SBIRT:

- Any positive screening result
- Residents at risk of substance-related harm
- Changes in health, behavior, or functioning

MA SBIRT Free trainings and resources: masbirt.org

Reference:

Substance Abuse and Mental Health Services Administration. (2011). SBIRT: Screening, brief intervention, and referral to treatment. U.S. Department of Health and Human Services. SBIRT: Screening, Brief Intervention, and Referral to Treatment

TAPS

Appendix H

TAPS
(Tobacco, Alcohol, Prescription medications, and other Substances)

Purpose:

TAPS is a brief screening tool used to identify risky or problematic use of tobacco, alcohol, prescription medications, and other substances.

When to use TAPS:

- At admission or intake
- When there are concerns about substance use beyond alcohol
- When additional screening is needed after a positive AUDIT-C or CAGE-AID

What TAPS screens:

Tobacco
Alcohol
Prescription medications (used non-medically)
Other substances

How TAPS fits into care:

- Helps identify residents who may need further assessment
- Supports early intervention and referral
- Can be used alongside alcohol-specific screening tools

Reference:

- McNeely, J., Wu, L. T., Subramaniam, G., Sharma, G., Cathers, L. A., Svikis, D., Saha, S., Bigelow, G., & Schwartz, R. P. (2016). Performance of the Tobacco, Alcohol, Prescription Medication, and Other Substance Use (TAPS) Tool for screening substance use in primary care patients. Journal of the American Medical Association, 315(11), 1167–1177. DOI:10.7326/M16-0317

Alcohol use withdrawal symptom checklist

Based on dsm-5

Appendix I

Use when: A resident has reduced or stopped drinking or shows sudden behavior changes.

A diagnosis requires 2 or more symptoms developing within hours to a few days after reduction/cessation.

Check all that apply:

- Sweating or elevated heart rate
- Hand tremors
- Trouble sleeping (insomnia)
- Nausea or vomiting
- Temporary hallucinations (visual, tactile, or auditory) or illusions
- Anxiety or nervousness
- Agitation or restlessness
- Seizures

Safety notes

- Withdrawal can be dangerous.
- Notify licensed nursing/medical staff immediately if symptoms are present.
- Seizures or hallucinations can be a medical emergency.

Overdose decision tree

Appendix J

Important: Always follow your facility's emergency protocols. Staff should notify licensed providers or EMS immediately in any suspected overdose.

Step	Action for staff	Decision/next step
1. Identify signs of overdose/alcohol poisoning	Look for: • Unresponsiveness or difficulty waking • Slow or irregular breathing (<10 breaths/min) • Blue lips or fingertips • Vomiting while unconscious • Confusion, extreme sleepiness, or agitation	Signs Present? Yes: Step 2 No: Monitor and educate residents
2. Activate emergency response	Follow Emergency Response Steps: 1. Check responsiveness gently shake and shout 2. Call emergency services (EMS) 3. Position in recovery pose (on side, head tilted) 4. Monitor breathing until help arrives 5. Rescue breathing if the person is not breathing 6. Do not leave alone or try to "sleep it off" 7. Naloxone if opioid use suspected	Continue to Step 3
3. Provide life-saving interventions	Administer naloxone (Narcan) if trained and opioid use suspected Begin CPR if breathing stops Ensure resident is stable until EMS arrives	Continue monitoring until EMS arrives
4. Monitor & document	Observe vital signs and level of consciousness Document incident thoroughly: • Signs observed • Actions taken • Time EMS called	Use information for post-event care planning and follow-up
5. Educate & prevent	• Train staff regularly on overdose recognition and emergency response • Post emergency protocols in visible locations • Provide naloxone training if appropriate • Review resident medications and alcohol use for risk reduction	Integrate prevention strategies into daily care routines

Quick tips for staff

- Always treat suspected overdose as a medical emergency.
- Keep emergency protocols and naloxone kits accessible.
- Regular training drills improve response time and safety.
- Document every event to inform care plans and future prevention.

AUD family & community support resources

Appendix K

Supporting residents with Alcohol Use Disorder (AUD) includes families, caregivers, and community programs. These resources help residents stay safe, healthy, and supported during treatment and after discharge.

Recovery organizations

Online and community-based groups can be helpful during alcohol withdrawal, active treatment and long-term support from others who have similar lived experiences.

SMART Recovery is the leading, evidence-informed approach to overcoming addictive behaviors and leading a balanced life. SMART is stigma-free and emphasizes self-empowerment. SMART stands for Self-Management and Recovery Training. The SMART methods are grounded in Rational Emotive Behavioral Therapy (REBT) and Cognitive Behavioral Therapy (CBT).

The goal is to help people:

- Build and maintain motivation
- Cope with urges and cravings
- Manage thoughts, feelings and behaviors
- Live a balanced life
- To find online or in-person meetings nearby, start here Find a meeting

Alcoholics Anonymous (AA) is a fellowship of people who come together to share their experience with AUD and receive support from others who understand. It does not cost anything to attend AA meetings and there are no age or education requirements to participate. Membership is open to anyone who wants to reduce their alcohol use or start on a path to recovery. AA works as a 12 step program.
Find a meeting
Meeting finder app: Alcoholics Anonymous® (AA) 212–870–3400

Life Ring Secular Recovery provides abstinence-based, secular, and self-directed recovery pathways through meetings and support communities. Learn more and find meetings here: Find a meeting 800–811–4142

AUD family & community support resources

Appendix K

Groups for family members

Families Anonymous (FA) provides fellowship for the family and friends of those individuals with alcohol or substance use disorder. FA offers virtual and in-person meetings. Meeting directory: Find a meeting

Al-Anon is a mutual support program for people who have a family member or friend with AUD. By sharing common experiences and applying the Al-Anon principles, families and friends can bring positive changes to their individual situations. Learn more and find a meeting here: Find a meeting

Other support groups for different conditions that may be co-occurring with AUD:
Narcotics Anonymous
Gamblers Anonymous

Massachusetts resources

Community Behavioral Health Centers (CBHCs) provide a wide range of mental health and substance use services and treatment. The statewide network of CBHCs includes centers across Massachusetts that offer immediate, confidential care for mental health and substance use needs. Find a center

Crisis services are available 24/7 for anyone in Massachusetts, regardless of health insurance status. CBHCs also offer day-to-day mental health and substance use services, which are covered by all MassHealth plans and some commercial insurance plans.

Aging Services Access Points (ASAPs) are located across the state and provide programs and services specifically designed to support adults aged 60 and older and their caregivers. Services include care coordination, support with housing, health and financial wellness, transportation, nutrition, and other programs. Find an Access Point

Massachusetts Older Adult Behavioral Health Network advocates for accessible, high-quality mental health and substance use services for older adults.

Veterans' Services programs & support from organizations in MA and nationally that serve veterans, active-duty military members, and their families.

AUD family & community support resources

Appendix K

National Alliance on Mental Illness, MA Chapter (NAMI MA)
NAMI offers peer support, family support, community education, and a helpline. Learn more

The Compass Helpline provides resources and support to help people navigate the mental health system and problem solve in difficult circumstances. Compass is available Monday through Friday, 10 am – 6 pm. Call 617-704-6264 or email compass@namimass.org

Dual Recovery Anonymous
Massachusetts Organization for Addiction Recovery (MOAR)
Recovery Binder
The Phoenix

- Massachusetts Substance Use Helpline: English Website; Spanish Website
  - The Helpline can help people seeking information for themselves or someone else (i.e., friend/family, patient, person receiving services).
  - Call 800-327-5050 or visit the helpline. This helpline has staff to assist in locating services or seeking information; also has a web directory to search for services if preferred.
  - Learn more about the Massachusetts Treatment system,
- Massachusetts Health Policy Commission**:** Integrating Telemedicine for Behavioral Health: Practical Lessons from the Field
- Bureau of Substance Addiction Services (BSAS) within the Department of Public Health www.mass.gov/orgs/bureau-of-substance-addiction-services (617) 624–5111
- Massachusetts Consultation Service for Treatment of Addition and Pain (MCSTAP) 1-833-PAIN-SUD (1-833-724-6783)
- The Massachusetts Screening, Brief Intervention, and Referral to Treatment Training & Technical Assistance (MASBIRT TTA)
- Peer Recovery Support Centers
- S.A.F.E. Project: Community Playbook
- S.A.F.E. Project NA and Persons Receiving Medication-Assisted Treatment: Pamphlet for Practitioners
- Gavin Foundation: Devine Recovery Center

AUD family & community support resources

Appendix K

National

988 Lifeline
The 988 Lifeline is for anyone facing mental health struggles, emotional distress, alcohol or drug use concerns, or for anyone who just needs someone to talk to. The Lifeline is available 24/7 and is free and confidential.

Professional Associations of Medical and Nonmedical Addiction Specialists

- American Academy of Addiction Psychiatry 401-524-3076
- American Psychological Association 1-800-374-2721
  - (Ask for your state's referral number to find psychologists with addiction specialties.)
- American Society of Addiction Medicine 301-656-3920

Treatment Finders
SAMHSA's Behavioral Health Treatment Services Locator
1-800-662-HELP (4357)

Medication chart

Appendix L

First-line medications for alcohol use disorder (AUD)i		
Generic name (Brand name)	**Naltrexone (Revia {oral} or Vivitrol {long-acting injection})**	**Acamprosate (Campral)**
Dose/frequencyii,iii	• 50mg by mouth daily • 380mg intramuscularly monthly	• 666mg by mouth three times daily • Should be taken with meals
Associated benefits	• Only taken once daily or monthly • Reduction in return to drinking and other drinking outcomes	• Very few medication interactions • Reduction in return to drinking and other drinking outcomes
Side effects	• Nausea (dose-dependent) • Dizziness • Vomiting	• Anxiety • Diarrhea • Vomiting
Contraindications	• Severe liver disease/use caution when prescribing to patients with elevated liver function tests • Patients using opioid pain medications or with anticipated needs for opiates • Hypersensitivity to naltrexone	• Severe renal disease • Hypersensitivity to acamprosate
Warnings/ precautions	• Vulnerability to opioid overdose and opioid withdrawal, risk of hospitalization for opioid withdrawal • Pregnancy Category C	• Alcohol dependent patients should be monitored for depression or suicidal thinking • Pregnancy Category C
Other considerations	• FDA approved for AUD	• FDA approved for AUD • Found to be most useful when people are abstinent from alcohol

Table(s) adapted from Overview of Medications Used in the Treatment of Alcohol Use Disorder and Frequently Asked Questions

Medication chart

Appendix L

Second-line medications for alcohol use disorder (AUD)iv			
Generic name (Brand name)	**Disulfiram (Antabuse)**	**Topiramate (Topamax)**	**Gabapentin (Neurontin)**
Dose/ frequencyv,vi,vii	• Initial dose: 500mg orally once a day (this dose is generally continued for the first 1 to 2 weeks) • Maintenance dose: 250 mg orally once a day (range: 125 mg to 500 mg once a day)	• Treatment typically starts low at 25 mg, taken in the evening. To minimize side effects, the dosage is gradually increased by 25–50 mg/week • Maintenance dose of 100–300 mg daily, divided into two doses. Doses above 300 mg/day are rarely needed	• 600 milligrams (mg) three times daily
Associated benefits	Shown effective in selected patients with strong psychosocial support to ensure adherence.	Shows promise for AUD treatment; studies indicate it can reduce or stop drinking.	Shows promise for AUD by reducing cravings, with added benefits for insomnia and anxiety.
Side effects	• Drowsiness • Metallic or garlic taste in mouth • Disulfiram reaction if exposed to alcohol (nausea, vomiting, diarrhea, tachycardia, hypotension, difficulty breathing)	• Paresthesia • Anorexia • Dizziness • Somnolence • Psychomotor slowing • Abnormal vision • Fever	• Dizziness • Nausea • Headache • Insomnia • Fatigue • Ataxia
Contraindications	• Psychosis • Severe heart disease • Hypersensitivity to disulfiram	• Hypersensitivity to topiramate	• Hypersensitivity to gabapentin
Warnings/ precautions	• Ingesting alcohol • Screen for cardiovascular or pulmonary disease, previous renal disease, hx of psychosis, diabetes, abnormal liver function, pregnancy	• Liver disease • Renal disease • Pregnancy Category C	• Myasthenia gravis • Renal disease • Pregnancy Category C
Other considerations	• FDA approved for AUD • Can effectively take away cravings for some people who have committed to the goal of abstinence from alcohol	• Off-label use for AUD • Already used in primary care practice	• Off-label use for AUD • Used in primary care practice • May work better for people with ongoing withdrawal symptoms • Monitor for opioid use

Table(s) adapted from Overview of Medications Used in the Treatment of Alcohol Use Disorder and Frequently Asked Questions

i EvidenceNow, Managing Unhealthy Alcohol Use, An AHRQ Initiative. 2022. Retrieved from https://integrationacademy.ahrq.gov/sites/default/files/2022-11/Medications%20for%20Alcohol%20Use%20FAQ.pdf
ii Drugs.com. 2026. Retrieved from https://www.drugs.com/dosage/naltrexone.html#Usual_Adult_Dose_for_Alcohol_Dependence
iii Drugs.com. 2026. Retrieved from https://www.drugs.com/dosage/acamprosate.html#Usual_Adult_Dose_for_Alcohol_Dependence
iv EvidenceNow, Managing Unhealthy Alcohol Use, An AHRQ Initiative. 2022. Retrieved from https://integrationacademy.ahrq.gov/sites/default/files/2022-11/Medications%20for%20Alcohol%20Use%20FAQ.pdf
v Drugs.com. 2026. Retrieved from https://www.drugs.com/dosage/disulfiram.html#Usual_Adult_Dose_for_Alcohol_Dependence
vi Bridge. Acute Care Treatment of Alcohol Use Disorder. 2020. Retrieved from https://bridgetotreatment.org/resource/acute-care-treatment-of-alcohol-use-disorder
vii Recovered. Topiramate: Uses, Effects, and Alcohol Use Disorder Treatment. 2025. Retrieved from https://recovered.org/treatment/addiction-treatment-medication/topiramate

Staff training checklist

Appendix M

This checklist confirms that staff have reviewed and understand how to use this toolkit to provide safe, respectful, and person-centered care for residents affected by alcohol use or Alcohol Use Disorder (AUD).

Staff Member: _____

Role/Title: _____

Date Completed: _____

Please check each box to confirm understanding:

- I understand that AUD is a health condition, not a personal failure, and that dignity and respect come first.
- I understand how alcohol use, AUD, and stigma can affect a resident's health, safety, and daily life.
- I use routine screening in a kind, nonjudgmental way to build trust and support safety.
- I work with residents (and families when appropriate) to plan care that respects choice, supports safety, and uses harm reduction when needed.
- I use person-first, respectful language and avoid blame, judgment, or labels in communication and documentation.
- I understand the signs of intoxication and withdrawal and know when to follow safety protocols.
- I know how to connect residents and families to community supports that match their goals and needs.
- I understand the importance of reflection, ongoing learning, and staff well-being in providing safe care.

Staff acknowledgement

I confirm that I have reviewed this toolkit, understand how to use it in my role, and agree to follow these principles in my daily work.

Staff Signature: _____ Date: _____

Trainer/Supervisor Name: _____

Trainer/Supervisor Signature: _____ Date: _____

Sample rest home policy

Appendix N

Title: Alcohol & Substance Use Policies

Policy Number: _____

Effective Date: _____

Review Date: _____

Approved By: _____

Purpose
To maintain resident safety and well-being by providing clear instructions for screening, alcohol use, intoxication or withdrawal management, and staff communication/privacy.

Scope
This policy applies to all staff members, including nursing, clinical, and support personnel who interact with residents.

Policy Statements

1. Screening & Documentation
    - Residents must be screened for alcohol and substance use at admission, annually, and whenever behavior or health changes.
    - Approved tools: AUDIT-C, CAGE-AID, TAPS, SBIRT.
    - Document: screening tool, score, observations, resident statements, and interventions.
    - Maintain confidentiality of all resident information.
    - Report positive screens to a licensed provider for evaluation.
2. Alcohol on Grounds
    - Alcohol is allowed only with assessment and provider approval.
    - Alcohol must be stored securely; staff supervise access as appropriate.
    - Document all consumption: amount, time, and observed effects.
    - Remove Alcohol for residents at risk of unsafe use, on contraindicated medications, or with medical restrictions.
3. Managing Intoxication or Withdrawal
    - Staff must recognize signs of intoxication (slurred speech, unsteady gait, confusion, odor) and withdrawal (sweating, tremors, nausea, agitation, anxiety, hallucinations, seizures).
    - Immediate actions:
        - Ensure resident safety
        - Notify licensed provider immediately
        - Follow care plan and monitoring protocols
        - Do not leave resident alone if at risk
        - Medical emergencies: seizures, hallucinations, or respiratory compromise. Call EMS immediately.

Sample rest home policy

Appendix N

4. Staff Communication & Privacy
    - Use non-stigmatizing, person-centered language.
    - Share resident information only with authorized staff, providers, and family (if permitted by resident).
    - Ensure documentation is accurate, timely, and stored securely (HIPAA compliant).
    - Staff should model supportive and respectful communication.

Emergency response steps (overdose / poisoning)

- Check responsiveness, gently shake and shout.
- Call emergency services (EMS).
- Position resident in recovery pose (on side, head tilted).
- Monitor breathing until help arrives.
- Do not leave resident alone or attempt to "sleep it off."
- Administer naloxone if opioid use is suspected and staff are trained.
- Provide rescue breathing while waiting for EMS after giving naloxone.

Staff acknowledgment

I have read, understand, and agree to follow the policies outlined above.

Staff name	Title	Signature	Date

Policy reviewed by: _____ Title: _____ Date: _____

Approved by: _____ Title: _____ Date: _____

References

1. Gould, W. R. (2025, October 27). Signs of different types of biases and how to overcome each of them. Verywell Mind. https://www.verywellmind.com/signs-of-bias-7501512
2. National Institute on Alcohol Abuse and Alcoholism. (2025, May 8). Stigma: overcoming a pervasive barrier to optimal care. National Institutes of Health. https://www.niaaa.nih.gov/health-professionals-communities/core-resource-on-alcohol/stigma-overcoming-pervasive-barrier-optimal-care
3. Desmon, S., & Morrow, S. D. (2014, October 1). Drug addiction viewed more negatively than mental illness, Johns Hopkins study shows. Johns Hopkins Magazine. https://hub.jhu.edu/2014/10/01/drug-addiction-stigma/
4. Center of Excellence for Behavioral Health in Nursing Facilities. (2024). Overcoming stigma in mental health [PDF]. Nursing Home Behavioral Health. https://nursinghomebehavioralhealth.org/wp-content/uploads/2024/04/MDD-Stigma-508-032924f_508.pdf
5. National Institute on Alcohol Abuse and Alcoholism. (n.d.). When it comes to reducing alcohol-related stigma, words matter. National Institutes of Health. https://www.niaaa.nih.gov/alcohols-effects-health/reducing-alcohol-related-stigma
6. National Institute on Alcohol Abuse and Alcoholism. (2025, August). Alcohol use disorder (AUD) in the United States: Age groups and demographic characteristics. National Institutes of Health. https://www.niaaa.nih.gov/alcohols-effects-health/alcohol-topics/alcohol-facts-and-statistics/alcohol-use-disorder-aud-united-states-age-groups-and-demographic-characteristics
7. National Institute on Alcohol Abuse and Alcoholism. (2025). Understanding Alcohol Use Disorder. National Institutes of Health. https://www.niaaa.nih.gov/publications/brochures-and-fact-sheets/understanding-alcohol-use-disorder
8. Alis Behavioral Health Staff. (2024, October 7). Alcohol use vs. alcoholism demystified. Alis Behavioral Health. https://www.alisbh.com/blog/alcohol-use-vs-alcoholism/
9. National Institute on Alcohol Abuse and Alcoholism. (2025, December). Aging and alcohol. National Institutes of Health. https://www.niaaa.nih.gov/alcohols-effects-health/aging-and-alcohol
10. National Institute on Alcohol Abuse and Alcoholism. (2007). Harmful interactions: Mixing alcohol with medicines (NIH publication). National Institutes of Health. https://www.niaaa.nih.gov/sites/default/files/publications/Harmful_Interactions.pdf HathiTrust
11. National Institute on Alcohol Abuse and Alcoholism. (2019). Interrupted memories: Alcohol-induced blackouts. National Institutes of Health. https://www.niaaa.nih.gov/publications/brochures-and-fact-sheets/interrupted-memories-alcohol-induced-blackouts
12. Prochaska, J. O., & Velicer, W. F. (1997). The transtheoretical model of health behavior change. American Journal of Health Promotion, 12(1), 38–48. https://doi.org/10.4278/0890-1171-12.1.38
13. Centers for Disease Control and Prevention. (2024). Overdose prevention. U.S. Department of Health and Human Services. https://www.cdc.gov/drugoverdose/prevention/index.html
14. National Institute on Alcohol Abuse and Alcoholism. (2023). Overdose prevention. National Institutes of Health. https://www.niaaa.nih.gov
15. Figley, C. R. (2002). Compassion fatigue: Psychotherapists' chronic lack of self-care. Journal of Clinical Psychology, 58(11), 1433–1441. https://doi.org/10.1002/jclp.10090
16. Stamm, B. H. (2010). The concise ProQOL manual (2nd ed.). ProQOL.org.