



PSYCHCE

Opioid Use in Older Adults: Clinical Considerations for Psychologists



Section 1: Introduction to Opioid Use in Older Adults: Why Psychologists Need This Knowledge	7
Introduction	7
Older Adults and the Changing Face of the Opioid Crisis	7
Why Older Adults Represent a Unique Clinical Population	9
The Psychological Experience of Chronic Pain and Aging	9
Distinguishing Therapeutic Use, Misuse, and Opioid Use Disorder	11
Ethical and Professional Responsibilities	11
Summary	12
Section 2: Epidemiology and Risk Factors in Older Adult Opioid Use	13
Introduction	13
Opioid Use in an Aging Population	14
Changing Patterns of Opioid Misuse and Opioid Use Disorder	15
Age-Related Vulnerability to Adverse Outcomes	16
Chronic Pain as a Risk Factor	17
Psychiatric Comorbidity and Opioid Risk	18
Social Determinants of Health and Health Disparities	19
Summary	20
Section 3: Aging, Pharmacology, and Medical Complexity	20
Introduction	20
Understanding Age-Related Physiological Changes	21
Chronic Pain and Medical Complexity	22

Cognitive Effects of Opioid Use in Older Adults	23
Falls, Frailty, and Functional Decline	24
The Psychologist's Role in Medical Collaboration	24
Summary	25
Section 4: Clinical Assessment of Older Adults With Opioid-Related Concerns	26
Introduction	26
The Biopsychosocial Foundation of Assessment	27
Establishing Rapport and Conducting the Clinical Interview	28
Screening for Opioid Misuse and Opioid Use Disorder	29
Comprehensive Pain Assessment	30
Assessing Mental Health and Psychiatric Comorbidity	31
Functional Assessment and Daily Living	32
Risk Assessment for Misuse, Overdose, and Accidental Harm	33
Summary	34
Section 5: Cognitive and Functional Assessment Considerations in Older Adults With Opioid-Related Concerns	34
Introduction	34
Cognitive Aging and Clinical Assessment	35
Mild Cognitive Impairment and Neurocognitive Disorders	36
Cognitive Screening in Clinical Practice	37
Functional Assessment and Independent Care	38
Summary	39

Section 6: Risk Assessment and Prevention of Opioid-Related Harm in Older Adults 40

Introduction	40
Understanding Opioid-Related Risk in Older Adults	41
Assessing Risk for Opioid Misuse and Opioid Use Disorder	41
Suicide Risk and Intentional Overdose	43
Prescription Drug Monitoring Programs (PDMPs): Using Prescription Data to Strengthen Risk Assessment	44
Naloxone and Overdose Prevention	50
Risk Mitigation Through Behavioral Interventions	52
Summary	52

Section 7: Evidence-Based Psychological Interventions for Older Adults With Opioid-Related Concerns

Introduction	53
Cognitive Behavioral Therapy for Chronic Pain and Opioid-Related Concerns ..	53
Acceptance and Commitment Therapy	54
Motivational Interviewing	55
Behavioral Activation	56
Mindfulness-Based Interventions	57
Integrated Treatment for Co-Occurring Mental Health Conditions	58
Adapting Psychological Interventions for Older Adults	59
Clinical Case Example	60
Summary	61

Section 8: Supporting Adherence and Self-Management in Older Adults With Opioid-Related Concerns	61
Introduction	61
Understanding Barriers to Adherence	62
Promoting Medication Adherence and Safety	63
Self-Efficacy and Health Behavior Change	64
Behavioral Strategies for Chronic Pain Self-Management	65
The Role of Family and Caregivers	66
Summary	66
Section 9: Interdisciplinary Collaboration and Integrated Care for Older Adults With Opioid-Related Concerns	67
Introduction	67
The Biopsychosocial Foundation of Integrated Care	68
Key Members of the Interdisciplinary Team	68
Communication in Interdisciplinary Practice	69
Integrated Care for Opioid Use Disorder	70
Working With Families and Caregivers	71
Summary	71
Section 10: Ethical and APA Practice Considerations	72
Introduction	72
Professional Competence and Scope of Practice	73
Informed Consent and Shared Decision-Making	73

Decision-Making Capacity and Cognitive Impairment.....	74
Confidentiality and Family Involvement	75
Documentation and Record Keeping	76
Ethical Management of Risk	76
Summary	77
Section 11: Cultural Competence and Diversity Considerations in Older Adults	
With Opioid-Related Concerns	78
Introduction.....	78
Cultural Beliefs About Pain and Aging	79
Racial and Ethnic Disparities in Pain and Substance Use Treatment	79
Rural Communities and Healthcare Access	80
LGBTQ+ Older Adults	81
Socioeconomic Factors and Social Determinants of Health	81
Cultural Humility in Clinical Practice	82
Medicare Coverage and Access Considerations	83
Summary	84
Section 12: Case Studies and Practical Applications	
Introduction.....	85
Case Study 1: Chronic Pain, Depression, and Escalating Opioid Use	85
Case Study 2: Mild Cognitive Impairment and Medication Safety.....	86
Case Study 3: Opioid Use Disorder and Integrated Care	87
Case Study 4: Cultural Considerations and Healthcare Mistrust	88

Summary	89
Section 13: Future Directions and Emerging Trends in Older Adult Opioid Care....	89
Introduction	89
Expanding Access to Medications for Opioid Use Disorder	90
Advances in Integrated and Collaborative Care	90
Telehealth and Digital Health Innovations	91
Addressing Health Disparities	91
Conclusion	92
References	93



Section 1: Introduction to Opioid Use in Older Adults: Why Psychologists Need This Knowledge

Introduction

Psychologists are uniquely positioned to recognize the psychological, behavioral, cognitive, and social factors that influence opioid use in later life. We encounter older adults across diverse settings, including outpatient mental health clinics, primary care practices, hospitals, rehabilitation programs, skilled nursing facilities, and integrated healthcare systems. We assess depression in patients coping with chronic pain, support caregivers overwhelmed by increasing responsibilities, evaluate cognitive changes that affect medication adherence, and help patients navigate grief, isolation, and declining physical health. In many cases, opioids become part of this complex clinical picture.

Opioid-related concerns require a biopsychosocial understanding that acknowledges the intersection of aging, pain, mental health, cognitive functioning, social circumstances, and healthcare systems. Psychologists possess expertise that extends beyond symptom reduction. We help patients adapt to life transitions, develop coping strategies, improve treatment adherence, and preserve quality of life during periods of significant vulnerability. Increasingly, this expertise must include an understanding of opioid use and opioid-related risk in later adulthood.

Older Adults and the Changing Face of the Opioid Crisis

The opioid epidemic has evolved substantially over the past two decades. Early public health attention focused primarily on inappropriate prescribing practices and the rising prevalence of opioid misuse among younger populations.

In reality, opioid use among adults aged 65 years and older has increased significantly over time. Many older adults receive opioid medications for legitimate medical indications, including osteoarthritis, neuropathic pain, cancer-related pain, spinal disorders, and post-surgical recovery. At the same time, the aging of the population means that more individuals with long-standing substance use histories are surviving into older adulthood. Consequently, healthcare professionals increasingly encounter older adults who present with prescription opioid dependence, opioid misuse, opioid use disorder (OUD), or opioid-related complications.

Dufort and Samaan (2021) noted that problematic opioid use among older adults represents an emerging public health concern that has historically received insufficient attention. Their review highlighted that opioid-related problems in later life are associated with increased morbidity and mortality, including sedation, cognitive impairment, falls, fractures, constipation, respiratory depression, and overdose. Importantly, these concerns often occur in the context of multiple chronic medical conditions and complex medication regimens.

One reason opioid-related problems may go unrecognized in older adults is that their presentation frequently differs from that of younger individuals. Older adults may be less likely to engage in overtly risky behaviors traditionally associated with substance misuse. Instead, concerns may emerge through missed appointments, confusion regarding medication schedules, increased falls, social withdrawal, mood changes, worsening cognitive complaints, or repeated requests for early prescription refills. Family members and healthcare providers may attribute these symptoms to normal aging rather than considering the possibility of opioid-related complications.

As psychologists, recognizing these subtler presentations is essential. The ability to identify when pain management transitions into problematic use requires

sensitivity, clinical curiosity, and an appreciation for the unique developmental context of later life.

Why Older Adults Represent a Unique Clinical Population

Older adulthood is accompanied by numerous physiological changes that alter how medications are absorbed, distributed, metabolized, and eliminated. Age-related declines in renal and hepatic functioning can reduce the body's ability to process medications efficiently, increasing the likelihood of adverse effects even at therapeutic doses. Changes in body composition, including decreased lean body mass and increased adipose tissue, further influence medication pharmacokinetics. These age-related pharmacokinetic changes and their clinical implications are covered in depth in Section 3.

These physiological realities directly influence psychological functioning. Sedation may contribute to depressive symptoms. Medication confusion can mimic cognitive decline. Chronic pain may exacerbate anxiety and social isolation. Falls may increase fear, reduce independence, and contribute to diminished self-efficacy. Without understanding the broader medical context, psychologists risk misunderstanding the emotional and behavioral presentations of older adults.

The Psychological Experience of Chronic Pain and Aging

Chronic pain is among the most common reasons older adults are prescribed opioids. However, pain is rarely a purely physical experience. Psychological factors influence how pain is perceived, interpreted, and managed.

Many older adults live with conditions that involve persistent discomfort, including arthritis, neuropathy, osteoporosis, spinal degeneration, and cancer-related pain. Over time, chronic pain can erode emotional well-being and alter

identity. Individuals who once viewed themselves as independent and capable may begin to see themselves as burdensome or limited. Activities that once brought meaning and connection become increasingly difficult to maintain.

Depression and anxiety frequently coexist with chronic pain. Sleep disturbances, fatigue, reduced physical activity, and social withdrawal may create a cycle in which emotional distress amplifies pain perception, which in turn worsens psychological symptoms. Feelings of grief and loss are also common. Older adults may mourn declining health, diminished mobility, retirement-related changes, or the deaths of loved ones.

Psychologists are particularly well equipped to address these interconnected experiences. Through evidence-based interventions, psychoeducation, and supportive psychotherapy, we help individuals develop adaptive coping strategies, strengthen resilience, and preserve valued aspects of identity despite physical limitations. Understanding the psychological dimensions of chronic pain is therefore central to competent opioid-related care.

Psychologists also contribute substantially through interdisciplinary collaboration. Effective care for older adults frequently requires coordination among primary care providers, geriatricians, pain specialists, pharmacists, nurses, physical therapists, and social workers. Within these teams, psychologists bring expertise in behavioral assessment, motivational enhancement, cognitive functioning, family systems, and health behavior change. Equally important is psychoeducation. Older adults and their families often struggle to distinguish between physical dependence, tolerance, misuse, and addiction. Providing accurate information reduces stigma and supports informed decision-making.

Distinguishing Therapeutic Use, Misuse, and Opioid Use Disorder

One of the greatest clinical challenges involves distinguishing appropriate opioid use from problematic use. Many older adults use opioid medications exactly as prescribed and experience meaningful improvements in functioning and quality of life. Physical dependence and tolerance may occur during long-term treatment and, by themselves, do not indicate addiction or opioid use disorder. Confusing these concepts may contribute to unnecessary shame and reluctance to discuss concerns openly.

At the same time, problematic opioid use can develop gradually. Misuse may involve taking higher doses than prescribed, using medications to manage emotional distress rather than pain, borrowing medications from others, or experiencing increasing difficulty controlling use. Older adults may not recognize these behaviors as problematic, particularly when opioids originated from legitimate medical treatment.

Diagnosing OUD in older adults presents additional complexity. DSM-5-TR criteria include features such as impaired control, social impairment, risky use, and physiological symptoms. However, retirement, reduced social demands, limited driving, and changing life roles may obscure some manifestations of impairment. Psychologists must therefore interpret diagnostic criteria within the developmental and contextual realities of aging.

Ethical and Professional Responsibilities

The APA Ethical Principles of Psychologists and Code of Conduct (APA, 2017) emphasize practicing within one's boundaries of competence, maintaining awareness of individual differences, and basing professional judgments on established scientific knowledge. These principles are highly relevant when working with older adults affected by opioid-related concerns.

Psychologists must recognize the limits of their expertise and pursue additional training when necessary. Competent practice includes understanding age-related vulnerabilities, screening appropriately for substance use concerns, appreciating the effects of chronic medical illness, and collaborating effectively with other healthcare professionals.

Avoiding ageism is equally important. Older adults are sometimes perceived as less likely to benefit from substance use treatment or less capable of behavior change. These assumptions are inconsistent with available evidence. Dufort and Samaan (2021) concluded that older adults can respond well to treatment for opioid-related disorders and that age alone should never serve as a barrier to intervention.

Finally, psychologists have ethical obligations to approach these conversations with compassion. Many older adults experience profound shame regarding opioid-related difficulties, particularly when medications originated from legitimate efforts to relieve suffering. Creating a therapeutic environment characterized by respect, curiosity, understanding, and hope is essential.

Summary

Opioid-related concerns among older adults represent an increasingly important area of psychological practice. This population experiences unique vulnerabilities related to physiological aging, chronic pain, polypharmacy, cognitive changes, and psychosocial stressors that can complicate both assessment and treatment. Yet older adults also demonstrate remarkable resilience and often respond positively to thoughtful, interdisciplinary, and evidence-based interventions.

Psychologists are uniquely positioned to identify emerging concerns, address the emotional and behavioral dimensions of chronic pain, support treatment adherence, collaborate across healthcare settings, and advocate for

compassionate care that preserves dignity and autonomy. Developing competence in this area is therefore not an optional specialization reserved for addiction professionals. It is increasingly a core component of ethical and effective psychological practice.

Section 2: Epidemiology and Risk Factors in Older Adult Opioid Use

Introduction

Understanding the epidemiology of opioid use among older adults is essential for psychologists who work in healthcare, mental health, rehabilitation, and community settings. While opioid-related concerns are often discussed in the context of younger populations, demographic shifts and changing prescribing patterns have created a growing need for psychologists to understand how opioid use affects individuals later in life. As the population ages, clinicians increasingly encounter older adults who are prescribed opioids for chronic pain, recovering from opioid-related complications, or experiencing opioid use disorder (OUD).

The epidemiology of opioid use among older adults differs from that observed in younger populations. Many older adults initially encounter opioids through legitimate medical treatment rather than recreational use. Chronic pain conditions, surgical procedures, cancer treatment, and degenerative musculoskeletal disorders frequently result in opioid exposure. Although many individuals use these medications safely and appropriately, age-related vulnerabilities can increase the risk of adverse outcomes, misuse, dependence, and overdose. Importantly, epidemiological evidence indicates that opioid-related morbidity is not limited to younger populations. The prevalence of diagnosed OUD among Medicare beneficiaries aged 65 years and older increased from

approximately 4.6 per 1,000 beneficiaries in 2013 to 15.7 per 1,000 in 2018, representing more than a threefold increase (Pytell et al., 2025). For psychologists, understanding these epidemiological patterns provides a foundation for effective screening, assessment, intervention, and interdisciplinary collaboration.

Opioid Use in an Aging Population

The United States is experiencing an unprecedented demographic transition. According to the U.S. Census Bureau, adults aged 65 years and older represent one of the fastest-growing segments of the population. As life expectancy increases and the Baby Boomer generation continues to age, healthcare providers are treating a larger number of older adults with chronic medical conditions, many of which involve persistent pain.

Pain is among the most common reasons older adults seek medical care. Conditions such as osteoarthritis, spinal stenosis, diabetic neuropathy, rheumatoid arthritis, osteoporosis, cancer, and post-surgical complications frequently result in chronic pain that can significantly impair functioning and quality of life. Although treatment approaches increasingly emphasize multimodal pain management, opioids remain part of the treatment plan for many patients.

Research indicates that older adults receive opioid prescriptions at higher rates than many younger age groups because of their greater burden of chronic illness and pain-related conditions (Dufort & Samaan, 2021). Prescription exposure remains clinically significant within this population. In a nationally representative analysis of approximately 2.3 million Medicare beneficiaries aged 65 years and older per year, 6.64% received at least one new opioid prescription in 2013; this proportion increased to 10.32% in 2015 before declining to 8.14% in 2016. Among beneficiaries receiving a new opioid prescription, approximately 10%–12% subsequently met criteria for long-term opioid use during the study period (Dufort

& Samaan, 2021). While prescription opioid rates have declined nationally in recent years following increased public health attention, a substantial number of older adults continue to receive opioid medications for both acute and chronic pain management.

Importantly, opioid exposure among older adults does not necessarily indicate problematic use. Most individuals prescribed opioids do not develop OUD. However, exposure creates opportunities for adverse effects and increases the importance of monitoring, education, and ongoing assessment. Psychologists should avoid assumptions that all opioid use is problematic while remaining attentive to factors that may increase risk over time.

Changing Patterns of Opioid Misuse and Opioid Use Disorder

Historically, substance use disorders among older adults were significantly underrecognized. Recent evidence suggests that rates of substance use disorders among older adults are increasing. Several factors contribute to this trend. First, many individuals who experienced substance use disorders earlier in life are now aging into older adulthood. Second, greater access to prescription opioids over previous decades increased exposure among adults who may not have otherwise encountered these medications. Third, improvements in healthcare and addiction treatment have allowed more individuals with substance use histories to survive into later life.

Pytell et al. (2025) noted that OUD among older adults remains underdiagnosed despite growing clinical significance. As noted previously, Medicare data indicate that diagnosed OUD prevalence among adults aged 65 years and older increased from 4.6 to 15.7 per 1,000 beneficiaries between 2013 and 2018. In addition to increasing prevalence, opioid-related hospitalizations and overdose deaths have risen among older adults, demonstrating that the consequences of opioid use

extend beyond prescription exposure alone (Pytell et al., 2025). Older adults may not fit common stereotypes associated with addiction, and clinicians may be less likely to screen for substance use concerns in this population. Furthermore, family members and healthcare providers may interpret behavioral changes as evidence of normal aging rather than considering substance-related causes.

More recent Medicare data also illustrate the substantial medical and psychiatric complexity of older adults diagnosed with OUD. Among 69,380 Medicare beneficiaries over age 65 with OUD in 2022, approximately 79% had chronic pain and arthritis, while approximately half had anemia, depression, or anxiety (Kuo et al., 2025). Despite this level of clinical complexity, only 15.0% received medication for OUD in 2022. Although this represented an improvement from 4.8% in 2017 and 7.5% in 2019, the findings indicate a persistent treatment gap among older adults with diagnosed OUD (Kuo et al., 2025).

The consequences of delayed identification can be substantial. Untreated opioid-related problems may contribute to worsening physical health, psychiatric symptoms, nonadherence to medication, increased healthcare utilization, and reduced quality of life. Early identification and intervention therefore represent critical clinical priorities.

Age-Related Vulnerability to Adverse Outcomes

Although opioid misuse and OUD warrant attention, many of the most significant opioid-related concerns among older adults involve adverse effects that occur even when medications are taken as prescribed. Physiological changes associated with aging increase vulnerability to medication-related complications and may magnify the effects of opioids on cognition, balance, respiratory functioning, and overall health. Older adults are particularly vulnerable because opioid exposure frequently occurs in the context of multimorbidity, chronic pain, psychiatric

conditions, polypharmacy, and age-related changes in medication metabolism and clearance (Dufort & Samaan, 2021; Pytell et al., 2025). These effects meaningfully increase fall risk, discussed fully in Section 3.

Opioid use has also been associated with increased risk of cognitive impairment. Difficulties with attention, memory, processing speed, and executive functioning may interfere with medication management and daily functioning. For some individuals, opioid-related cognitive effects can resemble symptoms of mild neurocognitive disorder or dementia, complicating assessment and diagnosis.

Respiratory depression remains another important concern. Age-related changes in pulmonary functioning combined with co-occurring medical conditions such as chronic obstructive pulmonary disease, sleep apnea, or cardiovascular disease may increase susceptibility to opioid-related respiratory complications. When opioids are combined with other central nervous system depressants, these risks become even greater.

Psychologists should recognize that adverse outcomes often occur through the interaction of multiple risk factors rather than any single cause. The epidemiological picture therefore reflects more than an increase in OUD diagnoses: older adults with opioid exposure often have overlapping medical, psychiatric, cognitive, and medication-related vulnerabilities that can amplify risk even in the absence of intentional misuse. Effective assessment requires attention to the broader biopsychosocial context in which opioid use occurs.

Chronic Pain as a Risk Factor

Chronic pain itself is among the strongest predictors of opioid exposure and opioid-related complications in older adulthood. The relationship between pain and opioid use is complex and extends far beyond physical symptoms. Persistent pain often disrupts sleep, limits physical activity, reduces social engagement, and

contributes to emotional distress. Individuals living with chronic pain frequently report feelings of frustration, helplessness, grief, and diminished self-worth. These experiences may increase vulnerability to depression and anxiety, both of which are associated with greater risk for problematic opioid use.

Pain can also influence decision-making regarding medication use. Individuals experiencing severe discomfort may be more likely to increase medication doses, take medications more frequently than prescribed, or use opioids in response to emotional distress rather than physical pain alone. Such behaviors may emerge gradually and without conscious intent to misuse medications.

For psychologists, assessing pain-related beliefs, coping strategies, emotional functioning, and quality of life is an essential component of comprehensive opioid-related care. Effective intervention often requires addressing both the physical and psychological dimensions of pain simultaneously.

Psychiatric Comorbidity and Opioid Risk

Mental health conditions significantly influence opioid-related outcomes among older adults. Depression, anxiety disorders, posttraumatic stress disorder, complicated grief, and sleep disorders frequently coexist with chronic pain and opioid use. The relationship between psychiatric symptoms and opioid use is often bidirectional. Chronic pain may contribute to emotional distress, while depression and anxiety can intensify pain perception and impair coping abilities. Individuals experiencing psychological distress may be more likely to rely on opioid medications as a means of emotional regulation, increasing vulnerability to problematic use. Psychologists are uniquely positioned to identify these patterns and intervene before they contribute to more serious consequences.

Depression, in regards to opioid-related risk, deserves particular attention. Dufort and Samaan (2021) identified depression as a significant risk factor for

problematic opioid use among older adults. Feelings of hopelessness, social withdrawal, and reduced engagement in meaningful activities may contribute to increased reliance on medications as a primary coping strategy.

Social isolation further compounds these concerns. Older adults may experience retirement, loss of loved ones, reduced mobility, caregiver stress, or shrinking social networks. These experiences can create loneliness and emotional pain that increase vulnerability to both mental health difficulties and substance-related concerns.

Social Determinants of Health and Health Disparities

Understanding opioid-related risk requires attention to the broader social context in which older adults live. Social determinants of health, including income, education, housing stability, healthcare access, transportation, and social support, significantly influence health outcomes. Older adults with limited financial resources may encounter barriers to nonpharmacological pain treatments such as physical therapy, psychological services, or specialized pain management programs. In these circumstances, opioid medications may become one of the few accessible treatment options.

Geographic location also influences risk. Older adults living in rural communities may experience limited access to healthcare providers, mental health services, addiction treatment programs, and specialty care. Transportation difficulties can further complicate treatment engagement.

Racial and ethnic disparities in healthcare add another layer of complexity. Historically marginalized populations have often experienced inequities in pain assessment, treatment access, and healthcare quality. The National Academies of Sciences, Engineering, and Medicine [NASEM] indicated that psychologists must remain attentive to these disparities and consider how systemic factors influence

both opioid use and treatment outcomes (NASEM, 2021). A culturally responsive approach recognizes that opioid-related concerns do not occur in isolation from broader social and environmental influences.

Summary

The epidemiology of opioid use among older adults reflects the intersection of chronic pain, aging, medical complexity, mental health, and social determinants of health. Although many older adults use opioid medications appropriately, age-related vulnerabilities increase the likelihood of adverse outcomes, including falls, cognitive impairment, overdose, and opioid use disorder.

Risk factors such as chronic pain, polypharmacy, depression, anxiety, social isolation, medical comorbidity, and limited access to care contribute to the complexity of opioid-related concerns in later life. Because these problems often present differently than they do in younger populations, psychologists must be prepared to recognize subtle warning signs and conduct comprehensive biopsychosocial assessments.

Section 3: Aging, Pharmacology, and Medical Complexity

Introduction

One of the most important realities psychologists must understand when working with older adults prescribed opioids is that aging changes how the body responds to medications. A medication regimen that may be tolerated reasonably well by a younger adult can produce significantly different effects in an older individual. These differences are not merely medical concerns. They directly influence

cognition, emotional functioning, behavior, treatment adherence, risk assessment, and quality of life. Consequently, psychologists who work with older adults must possess a working understanding of age-related pharmacological changes and the medical complexities that accompany later life.

Many referrals involving depression, anxiety, memory complaints, falls, fatigue, sleep disturbances, confusion, or reduced functioning occur within the context of multiple medical conditions and extensive medication regimens. In some cases, opioid medications may contribute to these presentations. In other situations, opioid use interacts with chronic illness, psychiatric symptoms, or additional medications in ways that complicate assessment and treatment. Without an appreciation of these interactions, psychologists may overlook important contributors to a patient's symptoms or misattribute medication-related effects to purely psychological causes.

Understanding Age-Related Physiological Changes

Aging is accompanied by numerous biological changes that affect how medications are processed and tolerated. These changes occur gradually and vary considerably across individuals. Nevertheless, several predictable physiological trends have important implications for opioid use.

One of the most significant changes involves reduced renal and hepatic functioning. The liver plays a central role in metabolizing many medications, while the kidneys are responsible for eliminating metabolic byproducts from the body. As individuals age, the efficiency of these systems often declines. Consequently, medications may remain in the body longer, resulting in prolonged effects and increased risk of accumulation.

Changes in body composition also affect medication distribution. Older adults typically experience decreases in lean muscle mass and total body water alongside

increases in body fat. These shifts alter how medications move through and are stored within the body. Some opioid medications may remain active for longer periods, increasing the likelihood of sedation and adverse effects.

Neurological changes further influence medication sensitivity. Older adults often demonstrate increased responsiveness to medications that affect the central nervous system. As a result, even therapeutic opioid doses may produce greater sedation, confusion, dizziness, or cognitive slowing than would be expected in younger populations.

From a psychological perspective, these physiological changes are highly relevant. Symptoms such as fatigue, memory difficulties, decreased concentration, slowed processing speed, or emotional lability may reflect medication effects rather than primary psychiatric disorders. Psychologists must therefore consider medical and pharmacological factors when evaluating behavioral or cognitive changes in older adults.

Chronic Pain and Medical Complexity

Chronic pain remains one of the most common reasons opioids are prescribed to older adults. However, chronic pain rarely exists in isolation. Most older adults experiencing persistent pain are simultaneously managing multiple medical conditions that influence treatment decisions and overall functioning.

Osteoarthritis, spinal disorders, neuropathic conditions, osteoporosis, cancer, cardiovascular disease, and diabetes frequently coexist. Each condition introduces additional challenges related to mobility, sleep, physical functioning, and emotional well-being. Pain often interacts with these conditions in ways that create a cycle of worsening disability and distress.

For example, persistent pain may reduce physical activity, contributing to deconditioning and increased fall risk. Reduced activity may then worsen

depressive symptoms and social isolation. Sleep disruption may intensify both pain perception and emotional distress. Over time, individuals may become increasingly reliant on medication as other coping resources diminish. Psychologists play a critical role in helping patients understand these interconnected processes. Effective treatment often requires addressing not only pain intensity but also behavioral patterns, emotional responses, beliefs about pain, and broader quality-of-life concerns.

Cognitive Effects of Opioid Use in Older Adults

Cognitive concerns are among the most common reasons older adults are referred for psychological or neuropsychological evaluation. Distinguishing opioid-related cognitive effects from age-related cognitive decline presents a significant clinical challenge. Opioids can affect attention, memory, processing speed, executive functioning, and psychomotor performance. These effects may be subtle or pronounced depending on dosage, duration of use, individual sensitivity, and the presence of other medications or medical conditions.

In clinical practice, patients frequently describe difficulty concentrating, forgetfulness, mental "cloudiness," or slowed thinking. Family members may notice reduced participation in conversations, impaired decision-making, or increased reliance on reminders and assistance. Comprehensive evaluation requires consideration of medication history, timing of symptom onset, medical conditions, psychiatric symptoms, and objective cognitive testing when appropriate. Psychologists should remain cautious about drawing conclusions regarding cognitive impairment without considering medication-related contributions. Collaboration with prescribing providers is often necessary to determine whether medication adjustments may improve cognitive functioning.

Falls, Frailty, and Functional Decline

Few opioid-related outcomes have greater implications for older adults than falls. Falls are a leading cause of injury, hospitalization, disability, and mortality in later life. Even when physical recovery occurs, psychological consequences can be profound. Following a fall, many older adults develop fear of falling, which may result in reduced activity, social withdrawal, and loss of independence. Confidence declines, mobility decreases, and quality of life may suffer substantially.

Opioids contribute to fall risk through multiple pathways, including sedation, dizziness, impaired balance, slowed reaction time, and cognitive impairment. Polypharmacy further amplifies these risks. Psychologists frequently encounter patients coping with the emotional aftermath of falls and declining physical function. Feelings of vulnerability, frustration, embarrassment, grief, and anxiety are common. Understanding the role medications may play in these experiences allows for more accurate assessment and effective intervention.

The Psychologist's Role in Medical Collaboration

The complexity of opioid use among older adults underscores the importance of interdisciplinary care. Psychologists bring a unique perspective that complements medical expertise. While physicians focus on diagnosis and medication management, psychologists contribute knowledge regarding cognition, behavior, emotional functioning, treatment adherence, coping strategies, and quality of life. Effective collaboration allows providers to identify concerns that may otherwise be overlooked.

For example, a psychologist may observe increasing confusion during therapy sessions, identify medication-related barriers to adherence, or recognize emerging depressive symptoms associated with chronic pain. Sharing these observations with medical providers supports more comprehensive and coordinated care.

Interdisciplinary communication is particularly important when evaluating cognitive complaints, assessing treatment adherence, managing chronic pain, or addressing concerns regarding opioid-related risk.

Summary

Aging significantly alters how the body processes and responds to opioid medications. Physiological changes, polypharmacy, chronic medical conditions, cognitive vulnerability, and increased sensitivity to medication effects combine to create a unique clinical context for older adults.

Psychologists who understand these factors are better equipped to interpret symptoms accurately, recognize medication-related complications, collaborate effectively with healthcare teams, and provide comprehensive care. Cognitive changes, emotional distress, falls, functional decline, and treatment adherence challenges often emerge through the interaction of medical, psychological, and pharmacological factors rather than any single cause.

Competent psychological practice with older adults therefore requires more than knowledge of mental health conditions alone. It demands an appreciation for the complex medical realities that shape functioning in later life and influence opioid-related outcomes.

Section 4: Clinical Assessment of Older Adults With Opioid-Related Concerns

Introduction

Assessment is one of the most important responsibilities psychologists assume when working with older adults who are prescribed opioid medications or who may be experiencing opioid-related complications. Accurate assessment forms the foundation for diagnosis, treatment planning, risk management, interdisciplinary collaboration, and ethical decision-making. In older adults, however, opioid-related concerns rarely present in a straightforward manner. Chronic pain, multiple medical conditions, polypharmacy, cognitive changes, depression, anxiety, grief, sleep disturbance, and functional limitations frequently coexist, creating complex clinical presentations that require thoughtful evaluation and careful clinical judgment (Dufort & Samaan, 2021; Pytell et al., 2025).

Unlike younger populations, opioid-related concerns in older adulthood often emerge gradually and may be difficult to recognize. A referral may initially focus on memory complaints, worsening depression, repeated falls, increasing confusion, treatment nonadherence, or declining independence rather than concerns about opioid use itself. Family members may report changes in behavior, mood, or functioning, while healthcare providers may notice inconsistent medication use or increasing healthcare utilization. These presentations may reflect opioid misuse, opioid use disorder (OUD), medication interactions, chronic illness, neurocognitive disorders, psychiatric conditions, or some combination of these factors (Substance Abuse and Mental Health Services Administration [SAMHSA], 2020). The psychologist's role is not merely to identify opioid use but to understand how biological, psychological, and social factors interact to influence overall functioning and well-being.

A comprehensive assessment therefore extends beyond symptom identification. Effective evaluation seeks to understand the individual's pain experience, medical history, cognitive functioning, emotional health, social environment, coping strategies, cultural background, and treatment goals. This person-centered approach is consistent with contemporary geropsychology and integrated healthcare models, which emphasize understanding the whole person rather than focusing narrowly on a single diagnosis or presenting problem (World Health Organization [WHO], 2023).

The Biopsychosocial Foundation of Assessment

A biopsychosocial framework provides the most effective foundation for assessing opioid-related concerns among older adults. Chronic pain and opioid use are influenced by multiple interacting factors that shape health outcomes, treatment adherence, and quality of life. Limiting assessment to medication use alone may overlook important contributors to distress and functional impairment.

Biological factors include chronic pain conditions, medical diagnoses, medication regimens, sleep quality, sensory impairments, mobility limitations, and age-related physiological changes. Older adults frequently manage multiple chronic illnesses simultaneously, including osteoarthritis, diabetes, cardiovascular disease, neuropathy, cancer, and neurological disorders. These conditions often influence both pain experiences and treatment decisions. Research has consistently demonstrated that age-related changes in medication metabolism and increased sensitivity to opioid effects contribute to elevated risks of falls, sedation, cognitive impairment, and overdose among older adults (Dufort & Samaan, 2021).

Psychological factors are equally important. Depression, anxiety, trauma histories, grief, loneliness, health-related fears, and pain catastrophizing can significantly influence how pain is experienced and managed. Older adults may sometimes rely

on opioid medications not only for pain relief but also as a means of coping with emotional distress associated with declining health, loss of independence, or social isolation. Understanding the emotional and behavioral functions of opioid use is critical for developing accurate case conceptualizations and effective treatment plans (Pytell et al., 2025).

Social and environmental influences must also be considered. Retirement, caregiver responsibilities, transportation difficulties, financial limitations, healthcare access, social support, and housing stability all affect health behaviors and treatment outcomes. SAMHSA (2020) notes that social isolation and reduced support networks are particularly important risk factors among older adults with substance use concerns. Comprehensive assessment therefore requires attention to both individual functioning and the broader context in which opioid use occurs.

Establishing Rapport and Conducting the Clinical Interview

The clinical interview remains one of the most valuable assessment tools available to psychologists. While standardized measures provide useful information, meaningful understanding often emerges through careful conversation, observation, and relationship building. Older adults may hesitate to discuss opioid use due to stigma, fear of being labeled as having an addiction, concerns about losing access to pain medication, or beliefs that substance use disorders primarily affect younger individuals. Establishing rapport and approaching assessment with curiosity rather than judgment are therefore essential.

The interview should explore the individual's pain history, medical conditions, medication regimen, psychiatric symptoms, social support system, and daily functioning. Questions should address when opioid use began, how medications are currently being used, perceived benefits and limitations of treatment, and any concerns regarding medication management. Clinicians should inquire about

changes in dosage over time, adherence to prescribing instructions, and experiences with previous pain management approaches.

Equally important is understanding the meaning that pain and medication use hold for the individual. Some older adults describe opioid medications as essential tools for maintaining independence and participating in valued activities. Others may acknowledge that medications help manage emotional distress in addition to physical pain. Exploring these experiences provides valuable insight into motivation, coping strategies, and potential treatment targets. A thorough interview also helps identify strengths and resilience factors that may support recovery and adaptation.

Screening for Opioid Misuse and Opioid Use Disorder

Screening is an important component of assessment because opioid-related concerns frequently go unrecognized among older adults. However, psychologists should recognize that many opioid screening instruments were originally developed using younger or middle-aged populations and may not fully capture the unique experiences of older adults. Screening results should therefore be interpreted within the context of a broader clinical evaluation rather than viewed as definitive indicators of misuse or OUD.

The Current Opioid Misuse Measure (COMM) and the Screener and Opioid Assessment for Patients with Pain-Revised (SOAPP-R) continue to be among the most commonly discussed tools for identifying opioid-related risk and problematic medication behaviors in chronic pain populations. More recent reviews suggest that these instruments can provide useful information when incorporated into comprehensive assessments but should not be relied upon as stand-alone diagnostic measures because factors such as chronic illness, cognitive changes,

and age-related functional limitations may influence responses (Finkelman et al., 2015).

Psychologists should also assess for DSM-5-TR criteria associated with OUD while remaining mindful of developmental and contextual considerations. Retirement, reduced social demands, physical disability, and changes in lifestyle may affect how symptoms manifest. For example, social impairment may be less apparent in an individual who already has a limited social network due to age-related circumstances. Clinical judgment remains essential when applying diagnostic criteria to older adults.

Comprehensive Pain Assessment

Pain assessment is central to evaluating opioid-related concerns because pain is often the primary reason opioids are prescribed. Effective pain assessment extends beyond numerical pain ratings and examines how pain affects the individual's functioning, emotional well-being, and quality of life.

A comprehensive pain evaluation should explore pain duration, intensity, location, frequency, aggravating factors, alleviating factors, and previous treatment experiences. Psychologists should also assess the impact of pain on sleep, physical activity, social engagement, mood, and participation in meaningful activities. Two individuals reporting similar levels of pain intensity may differ dramatically in their ability to function and cope effectively.

Pain-related cognitions are particularly important. Catastrophic thinking, fear avoidance, helplessness, and beliefs that pain inevitably signals worsening physical decline can contribute to increased distress and disability. Research identifies psychological factors that influence pain perception and treatment outcomes, making their assessment an essential component of comprehensive care (Eccleston et al., 2020). Understanding how individuals think about and respond

to pain helps identify opportunities for intervention and supports the development of more adaptive coping strategies.

Assessing Mental Health and Psychiatric Comorbidity

Psychiatric assessment is a critical component of opioid-related evaluation because mental health conditions frequently coexist with chronic pain and opioid use. Depression and anxiety are among the most common comorbid conditions and can significantly affect pain perception, treatment adherence, and quality of life.

Assessment should explore current symptoms, psychiatric history, trauma exposure, coping strategies, and prior treatment experiences. Older adults may present with depression in ways that differ from younger populations. Fatigue, irritability, reduced motivation, social withdrawal, hopelessness, and somatic complaints may be more prominent than overt sadness. Anxiety may manifest through excessive health-related concerns, fears regarding physical decline, or preoccupation with medication availability.

Trauma histories should also be assessed when clinically appropriate. Older adults may have experienced military combat, childhood adversity, interpersonal violence, medical trauma, or significant losses that continue to influence emotional functioning. Chronic pain and trauma-related symptoms frequently interact, creating additional complexity for assessment and treatment planning.

Suicide risk assessment is equally important, both through the clinical interview and through the use of validated screening and assessment measures. Although Item 9 of the Patient Health Questionnaire-9 (PHQ-9) can help identify the presence of thoughts of death or self-harm as part of depression screening, a more suicide-specific instrument such as the Columbia-Suicide Severity Rating Scale (C-SSRS) can provide a structured assessment of suicidal ideation and

suicidal behavior. The C-SSRS assesses clinically important dimensions of suicidal ideation, including severity, intent, and planning, as well as the presence and history of suicidal behaviors. Research has demonstrated associations between C-SSRS ideation severity and behavior scores and subsequent suicide death, supporting its utility as an initial component of suicide risk assessment (Bjureberg et al., 2022). Importantly, no screening instrument should be used in isolation to determine suicide risk; C-SSRS findings should be integrated with clinical interview data, history, current stressors, access to lethal means, and clinical judgment. Chronic pain, functional decline, social isolation, medical illness, and depression are all associated with elevated suicide risk among older adults. Assessment should include direct exploration of suicidal thoughts, hopelessness, perceived burdensomeness, reasons for living, and protective factors. A thorough understanding of both risk and resilience supports more effective intervention and safety planning.

Functional Assessment and Daily Living

One of the most clinically meaningful aspects of assessment involves understanding how opioid use, pain, and medical conditions affect daily functioning. Functional assessment focuses on the individual's ability to manage everyday responsibilities and maintain independence.

Areas of assessment may include medication management, transportation, financial management, meal preparation, housekeeping, personal care, and attendance at medical appointments. Difficulties in these areas may signal cognitive impairment, medication-related complications, physical limitations, or emerging safety concerns.

Psychologists should also assess treatment adherence and self-management skills. Older adults with chronic pain often navigate complex healthcare systems

involving multiple providers and treatment recommendations. Understanding how individuals organize medications, communicate with healthcare professionals, and manage chronic conditions provides valuable information regarding risk and support needs.

Collateral information from family members or caregivers may be particularly helpful when concerns exist regarding safety, cognition, or medication management. When obtained appropriately and with informed consent, collateral information can enhance assessment accuracy and contribute to more effective care planning.

Risk Assessment for Misuse, Overdose, and Accidental Harm

Risk assessment is a core responsibility when evaluating older adults who use opioids. Importantly, risk extends beyond the possibility of developing OUD. Many serious opioid-related outcomes occur among individuals who are taking medications as prescribed.

Assessment should address factors associated with overdose risk, including high opioid dosages, concurrent benzodiazepine use, respiratory illness, sleep apnea, cognitive impairment, previous overdose history, social isolation, and difficulties managing medications independently. Psychologists should explore understanding of medication instructions, adherence patterns, and any history of medication errors.

Risk assessment should also consider falls, impaired driving, accidental injuries, self-neglect, and functional decline. In older adults, these outcomes often have profound consequences for independence and quality of life. A comprehensive evaluation examines both current risk factors and protective factors, including family involvement, healthcare engagement, coping skills, and access to supportive services.

Summary

Clinical assessment of older adults with opioid-related concerns requires a comprehensive, biopsychosocial approach that integrates information regarding pain, medical health, cognitive functioning, psychiatric symptoms, social supports, and daily functioning. Effective assessment goes beyond identifying opioid use and seeks to understand how opioids interact with the broader realities of aging, chronic illness, and psychological well-being.

Psychologists play a critical role in identifying subtle warning signs, differentiating among potential causes of symptoms, evaluating risk, and collaborating with interdisciplinary healthcare teams. Through thoughtful interviewing, evidence-based assessment practices, careful clinical judgment, and person-centered care, psychologists can contribute substantially to the safe and effective treatment of older adults affected by opioid-related concerns.

Section 5: Cognitive and Functional Assessment Considerations in Older Adults With Opioid-Related Concerns

Introduction

One of the most important responsibilities of psychologists working with older adults is recognizing that changes in cognition and daily functioning can significantly influence the assessment and treatment of opioid-related concerns. Unlike younger populations, older adults frequently present with multiple interacting factors that affect cognitive performance, including chronic pain, sleep disruption, medication effects, medical illnesses, depression, anxiety, sensory impairments, and neurocognitive disorders. These factors may complicate

assessment findings and create challenges when determining whether observed difficulties reflect normal aging, medication effects, psychiatric conditions, substance-related problems, or emerging cognitive impairment.

From a clinical perspective, cognitive and functional assessment is not simply an adjunct to opioid-related evaluation. It is often central to understanding risk, treatment adherence, safety, decision-making capacity, and long-term outcomes. An older adult who forgets medication schedules, misunderstands dosing instructions, or struggles to recognize signs of overdose may face substantially greater risk than an individual with intact cognitive functioning. Similarly, impairments in executive functioning, judgment, or problem-solving can affect an individual's ability to participate effectively in treatment and make informed healthcare decisions.

Psychologists are uniquely positioned to evaluate these concerns through comprehensive assessment that integrates cognitive screening, functional evaluation, behavioral observation, collateral information, and clinical judgment. This section examines the relationship between cognition, functioning, and opioid-related concerns in older adults while providing practical guidance for assessment and clinical decision-making.

Cognitive Aging and Clinical Assessment

Normal aging is associated with certain predictable cognitive changes. Many older adults experience slower processing speed, reduced working memory efficiency, and occasional difficulties retrieving information. These changes do not necessarily indicate pathology and often have minimal impact on everyday functioning. However, distinguishing normal aging from clinically significant impairment can be challenging, particularly when chronic pain, opioid use, or medical illness is present.

Pain itself can influence cognitive performance. Individuals experiencing persistent pain often report difficulties with attention, concentration, memory, and mental efficiency. Research suggests that chronic pain competes for cognitive resources, reducing the capacity available for other tasks (Bell et al., 2022). As a result, older adults may perform below their true abilities during cognitive assessment when pain is poorly controlled.

Opioid medications may further complicate the clinical picture. Although many individuals tolerate opioid therapy without significant cognitive impairment, some experience sedation, slowed processing speed, reduced attention, or impaired psychomotor functioning. These effects may be more pronounced during medication initiation, dosage increases, or periods of polypharmacy. Psychologists should therefore consider medication timing and recent treatment changes when interpreting assessment findings.

Depression, anxiety, grief, and sleep disturbances may also contribute to subjective and objective cognitive complaints. Older adults frequently attribute concentration and memory problems to aging when emotional factors play a substantial role. Comprehensive assessment requires attention to these overlapping influences rather than relying solely on cognitive test scores.

Mild Cognitive Impairment and Neurocognitive Disorders

Mild Cognitive Impairment (MCI) occupies an intermediate position between normal aging and dementia. Individuals with MCI demonstrate measurable cognitive decline while largely maintaining independence in daily functioning. Research indicates that MCI affects approximately 10–20% of adults over age 65, although prevalence estimates vary depending on diagnostic criteria (Petersen et al., 2018).

The distinction between MCI and dementia has important implications for opioid-related care. Individuals with MCI may retain substantial decision-making abilities while experiencing subtle difficulties with medication management, appointment adherence, financial tasks, or complex healthcare decisions. These challenges can increase vulnerability to medication errors, accidental misuse, and treatment nonadherence.

Major neurocognitive disorders, including Alzheimer's disease and related dementias, create additional concerns. As cognitive impairment progresses, individuals may struggle to report pain accurately, remember medication instructions, recognize adverse effects, or participate meaningfully in treatment planning. Family involvement and interdisciplinary collaboration become increasingly important in these situations.

Psychologists should remain alert to signs suggesting possible neurocognitive disorder, including progressive memory decline, repetitive questioning, impaired judgment, difficulties managing finances, increasing dependence in daily activities, and concerns reported by family members or caregivers. Early identification allows for timely intervention and improved care planning.

Cognitive Screening in Clinical Practice

Cognitive screening is often appropriate when older adults present with opioid-related concerns, particularly when there are reports of memory problems, medication management difficulties, confusion, falls, or functional decline. Screening instruments do not establish diagnoses but can help identify individuals who may benefit from more comprehensive evaluation.

The Montreal Cognitive Assessment (MoCA) has become one of the most widely used cognitive screening tools for older adults because of its sensitivity to mild cognitive impairment and executive dysfunction (Nasreddine et al., 2005). The

MoCA assesses attention, memory, language, visuospatial abilities, executive functioning, and orientation. It is particularly useful when subtle cognitive changes are suspected.

The Mini-Mental State Examination (MMSE) remains widely recognized and may be useful in some settings, although it is generally less sensitive to early cognitive decline and executive deficits. Psychologists should understand the strengths and limitations of both instruments and interpret results within the broader clinical context.

Importantly, screening scores should never be interpreted in isolation. Educational background, cultural factors, language proficiency, sensory impairments, emotional functioning, and medical conditions can all influence performance. Cognitive screening is most valuable when integrated with clinical interviews, behavioral observations, and collateral information.

Functional Assessment and Independent Care

While cognitive testing provides valuable information, functional assessment often offers the clearest picture of how cognitive changes affect daily life. In many cases, functional impairment becomes clinically significant before cognitive deficits are obvious during formal testing.

Activities of Daily Living (ADLs) refer to basic self-care tasks such as bathing, dressing, eating, toileting, transferring, and maintaining personal hygiene. Instrumental Activities of Daily Living (IADLs) involve more complex activities necessary for independent living, including medication management, financial management, transportation, shopping, meal preparation, and appointment scheduling (American Psychological Association, 2019).

Among older adults with opioid-related concerns, medication management represents one of the most important functional domains to assess. Difficulties organizing prescriptions, remembering dosing schedules, understanding instructions, or recognizing adverse effects may significantly increase risk. Family members frequently notice these difficulties before clinicians become aware of them. Functional assessment should therefore include direct questioning regarding daily routines, healthcare management, transportation, household responsibilities, and medication use. Whenever possible, collateral information from family members or caregivers should be obtained to improve assessment accuracy.

Summary

Cognitive and functional assessment is a critical component of opioid-related evaluation among older adults. Chronic pain, opioid medications, medical conditions, emotional distress, and neurocognitive disorders may all influence cognitive performance and daily functioning. Psychologists must carefully distinguish among these factors while evaluating safety, treatment adherence, decision-making capacity, and independence.

Comprehensive assessment extends beyond cognitive screening to include evaluation of functional abilities, medication management, collateral information, and real-world behavior. Through thoughtful assessment and interdisciplinary collaboration, psychologists can identify risks early, support informed decision-making, and promote safer, more effective care for older adults experiencing opioid-related concerns.

Section 6: Risk Assessment and Prevention of Opioid-Related Harm in Older Adults

Introduction

Psychologists working with older adults who use opioids occupy an important position in identifying and reducing risk. Although opioid-related harm is often conceptualized primarily as a medical issue, psychological, behavioral, cognitive, and social factors frequently contribute to adverse outcomes. Older adults face unique vulnerabilities because age-related physiological changes, chronic medical conditions, polypharmacy, cognitive impairment, social isolation, and mental health concerns can all increase the likelihood of opioid-related complications. Consequently, psychologists must be prepared to recognize risk factors, conduct comprehensive assessments, and collaborate with interdisciplinary teams to support prevention efforts.

Risk assessment in older adults extends beyond identifying opioid misuse or opioid use disorder. Many adverse outcomes occur among individuals who are taking medications as prescribed. Falls, medication errors, accidental overdoses, respiratory depression, cognitive impairment, impaired driving, and dangerous medication interactions may develop even in the absence of intentional misuse. For this reason, psychologists should approach opioid-related risk assessment using a broad biopsychosocial framework that considers the interaction of medical, cognitive, emotional, behavioral, and environmental factors.

Effective prevention requires ongoing monitoring rather than a single assessment. Risk factors often change over time as health status, medication regimens, social support systems, and cognitive functioning evolve. Psychologists can contribute

significantly to early identification of emerging concerns, allowing interventions to occur before serious adverse events develop.

Understanding Opioid-Related Risk in Older Adults

Older adults are particularly vulnerable to opioid-related harm because of physiological changes associated with aging. Reduced hepatic metabolism, decreased renal clearance, changes in body composition, and increased central nervous system sensitivity can alter how opioid medications are processed and tolerated. As a result, older adults may experience stronger effects from medications that would produce fewer complications in younger individuals (Dowell et al., 2022).

The presence of multiple chronic health conditions further increases risk. Cardiovascular disease, respiratory disorders, sleep apnea, diabetes, neurological conditions, and chronic pain syndromes are common among older adults and may interact with opioid therapy in complex ways. These conditions often require multiple medications, increasing the likelihood of drug interactions and cumulative side effects.

Psychologists should recognize that risk is rarely attributable to a single factor. Instead, adverse outcomes often emerge through the combined influence of physical health concerns, emotional distress, cognitive changes, medication burden, and environmental factors. Comprehensive assessment therefore requires attention to the full clinical picture rather than focusing solely on opioid use.

Assessing Risk for Opioid Misuse and Opioid Use Disorder

Although many older adults use opioids appropriately, opioid misuse and opioid use disorder (OUD) remain important considerations. Misuse may include taking

medication more frequently than prescribed, increasing dosage without medical approval, obtaining opioids from multiple providers, using medication for emotional distress rather than pain, or sharing medications with others.

Older adults may present differently than younger populations. Classic indicators of substance misuse may be less obvious, and symptoms are sometimes mistaken for normal aging, depression, medical illness, or cognitive decline. Consequently, psychologists should maintain awareness of subtle warning signs such as escalating medication requests, unexplained functional decline, increasing social withdrawal, mood instability, or repeated reports of lost prescriptions.

Screening instruments can be useful when integrated with clinical interviews, medical record review, and collateral information. Several validated tools, including the Current Opioid Misuse Measure (COMM) and the Screener and Opioid Assessment for Patients with Pain–Revised (SOAPP-R), are commonly used to identify behaviors associated with an elevated risk for opioid misuse and to support ongoing monitoring of patients receiving opioid therapy (Finkelman et al., 2015). However, clinicians should recognize that many screening instruments were originally developed and validated in predominantly middle-aged chronic pain populations rather than older adults. As a result, screening results should be interpreted cautiously and integrated with comprehensive clinical assessment, cognitive evaluation, functional status, and collateral information when working with geriatric populations.

Assessment should also explore the role opioids serve in the individual's life. Some patients primarily use opioids to manage physical pain, while others may rely on medication to cope with grief, loneliness, anxiety, depression, or emotional distress. Understanding these functions provides valuable information for treatment planning and prevention efforts.

Suicide Risk and Intentional Overdose

Suicide risk assessment is a critical component of opioid-related care among older adults. Chronic pain, depression, social isolation, functional decline, bereavement, and serious medical illness all contribute to elevated suicide risk. Research indicates that older adults with chronic pain are at increased risk for suicidal ideation and suicide-related outcomes. In a large multistate analysis of 123,181 suicide deaths, 8.8% of individuals who died by suicide had documented chronic pain, and the proportion increased from 7.4% in 2003 to 10.2% in 2014. Among suicide decedents with chronic pain, 53.6% died from firearm-related injuries and 16.2% died from opioid overdose (Petrosky et al., 2018). These findings reinforce the importance of routinely assessing suicide risk when chronic pain, opioid exposure, functional decline, and psychiatric symptoms occur together.

Psychologists should assess both active and passive suicidal thoughts. Many older adults express hopelessness indirectly through statements such as, "I don't know how much longer I can do this," or "Sometimes I think everyone would be better off without me." These statements warrant careful exploration rather than dismissal as expressions of frustration.

Risk assessment should also consider medication access and overdose potential. Individuals experiencing suicidal ideation may view prescribed opioids as a means of self-harm. Comprehensive assessment therefore includes evaluation of intent, planning, protective factors, social supports, and access to potentially lethal medications. Protective factors deserve equal attention. Supportive relationships, engagement in healthcare, spiritual beliefs, meaningful activities, family connections, and future-oriented goals can significantly reduce risk and should be incorporated into treatment planning whenever possible.

Prescription Drug Monitoring Programs (PDMPs): Using Prescription Data to Strengthen Risk Assessment

Prescription Drug Monitoring Programs (PDMPs) are an important component of opioid-related risk assessment and harm prevention. A PDMP is a state-administered electronic database that collects information about prescriptions for controlled substances dispensed within that state. Depending on the jurisdiction, PDMP reports may include information about opioid medications, benzodiazepines, stimulants, and other controlled substances, as well as the dates medications were dispensed, quantities prescribed, prescribing clinicians, and dispensing pharmacies. The purpose of a PDMP is not to diagnose opioid use disorder (OUD), but rather to provide clinicians with additional information that can improve medication safety, identify potentially dangerous medication combinations, and support more informed clinical decision-making (Dowell et al., 2022).

Due to comprehensive integrated care, understanding PDMPs is increasingly relevant to psychological practice. Clinical psychologists frequently work with patients who have chronic pain, substance use disorders, complex medical conditions, or behavioral health concerns that influence medication management. This is particularly important when working with older adults, who may receive controlled medications from multiple specialists and may be especially vulnerable to medication interactions, cognitive impairment, falls, sedation, and respiratory depression.

Access to PDMP Information

PDMP access is regulated at the state level. Eligibility for direct access therefore varies according to state law, licensure, professional role, and clinical setting. Psychologists should become familiar with the requirements in the jurisdiction in

which they practice rather than assuming that their professional license automatically permits or prohibits access.

When psychologists are eligible for direct access, registration typically occurs through the state's PDMP system and may require verification of professional licensure, identity, clinical role, and the permissible purpose for accessing the database. PDMP information should only be accessed for legally authorized clinical purposes and handled as sensitive health information.

When direct access is not available to psychologists, PDMP information can still become an important part of interdisciplinary care. With appropriate authorization and within applicable privacy and organizational policies, psychologists can collaborate with physicians, advanced practice providers, pharmacists, pain specialists, addiction specialists, or other clinicians who are authorized to review the PDMP. For example, a psychologist conducting an evaluation of an older adult with chronic pain may ask the prescribing clinician whether the patient's controlled-substance history has been reviewed and whether there are medication patterns relevant to the psychological assessment or treatment plan.

The goal is not for the psychologist to independently manage medication therapy. Rather, PDMP information can contribute to a broader biopsychosocial understanding of the patient and help identify situations in which closer coordination with the prescribing team is warranted.

What Information Should Clinicians Look For?

PDMP information should be interpreted as one source of clinical data rather than as a stand-alone determination of risk. When reviewing a PDMP directly, or discussing findings with an authorized prescriber, several patterns may warrant additional assessment.

Multiple controlled-substance prescribers - Receiving controlled medications from several clinicians may indicate fragmented care, transitions between providers, multiple legitimate medical conditions, or, in some cases, attempts to obtain additional medication. The number of prescribers alone does not establish misuse or OUD.

Multiple dispensing pharmacies - Similarly, medications filled at different pharmacies may deserve clarification, particularly when this pattern occurs repeatedly. However, there may be reasonable explanations, including medication availability, insurance requirements, travel, relocation, or pharmacy closures.

Overlapping opioid prescriptions - Concurrent opioid prescriptions can increase total opioid exposure. Prescribers may use PDMP information to evaluate total opioid dosage and determine whether the combined regimen increases overdose risk (Dowell et al., 2022).

Concurrent opioids and other central nervous system depressants - Particular attention should be given to combinations of opioids with medications such as benzodiazepines because concurrent use can substantially increase the risk of sedation and respiratory depression. For an older adult, these combinations may also compound risks associated with impaired balance, cognition, and falls.

Early or unusually frequent prescription fills - Repeated early fills may warrant further assessment but should not automatically be interpreted as evidence of misuse. A psychologist might explore whether the patient is taking more medication than prescribed, misunderstanding instructions, experiencing inadequately controlled pain, losing medications, having memory problems, or experiencing difficulty organizing a complex medication regimen.

Changes in prescribing patterns - Sudden increases in medication quantity, the addition of another controlled substance, or changes in the number of prescribers

may provide useful clinical information. These findings should prompt clarification rather than immediate conclusions.

For psychologists working with older adults, these patterns should be considered alongside cognitive functioning, health literacy, psychiatric symptoms, pain severity, functional impairment, alcohol and other substance use, medication-management abilities, and the patient's broader medical history.

Interpreting PDMP Findings Without Stigmatizing the Patient

A central clinical principle is that a PDMP identifies prescription patterns, not diagnoses. A concerning pattern should generate a clinical question rather than a clinical conclusion.

For example, an older adult who has received opioid prescriptions from three different physicians may initially appear to be engaging in "doctor shopping." Further assessment may reveal that one prescription followed orthopedic surgery, another came from the patient's longstanding pain physician, and a third was prescribed during an emergency department visit. Conversely, a patient who receives all controlled substances from a single clinician may still be experiencing medication misuse or developing OUD.

The CDC specifically recommends interpreting PDMP information in the context of other clinical information rather than using it in isolation. PDMP-generated risk scores should not replace clinical judgment, and clinicians should not dismiss patients from care solely because of information identified in the PDMP (Dowell et al., 2022).

This distinction is particularly important for psychologists. Behavioral observations, psychological testing, patient self-report, collateral information, medical history, and PDMP findings may each provide different pieces of the clinical picture. None should automatically supersede the others.

Integrating PDMP Findings Into Psychological Assessment

For psychologists, the greatest value of PDMP information is its ability to generate additional clinical questions. When a concerning prescription pattern is identified, further assessment may examine:

- whether the patient understands how and when medications should be taken;
- whether medications are being taken differently than prescribed;
- whether pain or functional impairment has recently worsened;
- whether tolerance or withdrawal symptoms are present;
- whether there is evidence of craving, loss of control, or continued use despite harm;
- whether depression, anxiety, trauma symptoms, insomnia, or other psychiatric symptoms are contributing to medication use;
- whether alcohol, benzodiazepines, sleep medications, or other substances are being used concurrently;
- whether cognitive impairment is interfering with medication management;
- whether medications are being shared, lost, or obtained from sources outside the patient's established treatment team; and
- whether the patient meets DSM-5-TR criteria for OUD.

Special Considerations for Older Adults

PDMP findings can be especially useful when evaluating older adults because prescribing patterns that appear concerning may arise from circumstances that differ from those commonly seen in younger populations.

An older adult may have several legitimate prescribers because of care from primary care, orthopedics, oncology, surgery, pain management, or other specialties. Cognitive changes may also contribute to medication errors, including taking additional doses because the individual does not remember having taken the medication earlier. Transitions from a hospital or rehabilitation facility back to outpatient care can result in temporary overlapping prescriptions. Spouses or adult children may also be involved in medication management, adding another layer of complexity.

Clinical Takeaway

PDMP data should prompt inquiry

A concerning prescription history is a signal to gather additional information. It is not, by itself, evidence of addiction, deception, or inappropriate behavior. This distinction is particularly important in older adults, whose medication histories are often complicated by multimorbidity, multiple prescribers, care transitions, and polypharmacy.

Psychologists can add significant value by helping the treatment team understand the behavioral and psychological context surrounding prescription history. When PDMP information is integrated with careful assessment, non-stigmatizing communication, and interdisciplinary collaboration, it becomes a useful component of opioid-related harm prevention rather than simply a surveillance tool.

Naloxone and Overdose Prevention

Naloxone is an opioid antagonist that rapidly reverses the potentially fatal effects of an opioid overdose, particularly respiratory depression. It has no intoxicating effects and will not produce an opioid effect in someone who has not taken opioids. Naloxone can be administered by patients, family members, caregivers, or other individuals who recognize a possible overdose. For older adults, access to naloxone may be especially important because opioid-related risk often occurs in the context of chronic medical conditions, polypharmacy, cognitive changes, and the concurrent use of other medications that can increase sedation or respiratory depression. Naloxone should therefore be conceptualized not as evidence that a patient has an addiction, but as a practical safety intervention, similar to having other emergency medications available for individuals at increased medical risk (Dowell et al., 2022).

The 2022 CDC *Clinical Practice Guideline for Prescribing Opioids for Pain* recommends that clinicians incorporate strategies to mitigate overdose risk, including offering naloxone (Dowell et al., 2022). Naloxone is particularly important for patients with a history of overdose or substance use disorder, sleep-disordered breathing, higher opioid dosages (e.g., ≥ 50 morphine milligram equivalents [MME] per day), concurrent use of opioids and benzodiazepines, or circumstances in which an individual may return to a previously tolerated opioid dose after losing tolerance (Dowell et al., 2022). The 50 MME/day level should not be interpreted as a rigid threshold separating “safe” from “unsafe” opioid use; overdose risk increases progressively with opioid dosage. Rather, it represents an important point at which clinicians should reassess risk and implement additional precautions, including overdose education and offering naloxone.

Although psychologists typically do not prescribe opioid medications, they can play an important role in naloxone education and overdose prevention.

Psychologists working in pain management, behavioral medicine, rehabilitation, integrated care, or substance use treatment should be able to recognize patients who may benefit from naloxone and reinforce recommendations made by the prescribing team. This may include discussing the purpose of naloxone, correcting misconceptions about its use, encouraging patients to speak with their physician or pharmacist about obtaining it, and incorporating overdose prevention into broader discussions of medication safety. Psychologists should also recognize that naloxone availability remains underutilized among patients at increased risk. Recent national outpatient data found low rates of naloxone prescribing even among higher-risk patients receiving long-term opioid therapy, including individuals taking higher opioid dosages, those concurrently prescribed benzodiazepines, and those with a history of OUD (Miller et al., 2025).

Education should extend beyond the patient whenever appropriate. The CDC recommends providing overdose-prevention education to patients and offering education to household members because the person experiencing an overdose may be unable to administer naloxone independently (Dowell et al., 2022). Patients and families should understand basic warning signs of opioid overdose, including inability to awaken or respond, markedly slowed or absent breathing, and other evidence of severe respiratory depression. They should be instructed to administer naloxone according to product directions, activate emergency medical services, and recognize that additional doses may be necessary if the individual does not respond or symptoms return. Naloxone's effects are temporary, making emergency medical evaluation necessary even when the person initially improves.

For psychologists, the goal is not to assume the role of the prescriber, but to recognize overdose risk, provide accurate psychoeducation, involve families when appropriate, and collaborate with medical providers to ensure that patients have access to potentially lifesaving interventions.

Risk Mitigation Through Behavioral Interventions

Behavioral interventions play a central role in reducing opioid-related harm. Psychologists can help individuals develop coping skills, improve treatment adherence, manage emotional distress, and reduce reliance on medication as a primary coping strategy.

Interventions often focus on increasing activity engagement, strengthening social support, improving sleep, managing stress, addressing depression and anxiety, and promoting healthy pain coping strategies. These approaches not only improve quality of life but may also reduce risk factors associated with opioid-related complications.

Psychoeducation is equally important. Many older adults receive limited information regarding medication safety, overdose risk, storage practices, or disposal of unused medications. Providing accurate and understandable education can significantly improve patient safety and self-management.

Summary

Risk assessment and prevention are essential components of psychological practice with older adults who use opioids. Effective assessment extends beyond identification of misuse and includes evaluation of polypharmacy, falls, cognitive impairment, suicide risk, functional safety, and psychosocial stressors.

Psychologists contribute significantly to prevention through comprehensive assessment, behavioral intervention, psychoeducation, and interdisciplinary collaboration.

By recognizing risk early and implementing evidence-based prevention strategies, psychologists can help older adults maintain safety, improve functioning, and reduce the likelihood of opioid-related harm.

Section 7: Evidence-Based Psychological Interventions for Older Adults With Opioid-Related Concerns

Introduction

Psychologists play a vital role in the treatment of older adults experiencing opioid-related concerns. While medication management is often an important component of care, psychological interventions address many of the behavioral, cognitive, emotional, and social factors that contribute to pain, opioid reliance, treatment nonadherence, and diminished quality of life. Research shows that comprehensive treatment approaches integrating behavioral health services with medical care produce better outcomes than medication-focused interventions alone (Eccleston et al., 2020).

Older adults frequently present with complex clinical profiles that include chronic pain, depression, anxiety, grief, sleep disturbance, social isolation, functional limitations, and multiple medical conditions. Effective treatment therefore requires interventions that are flexible, evidence-based, and responsive to the realities of aging. Rather than focusing solely on symptom reduction, psychological treatment often aims to improve functioning, strengthen coping skills, enhance resilience, and support meaningful engagement in life activities.

Cognitive Behavioral Therapy for Chronic Pain and Opioid-Related Concerns

Cognitive Behavioral Therapy (CBT) remains one of the most extensively studied psychological interventions for chronic pain and opioid-related conditions. CBT is based on the premise that thoughts, emotions, behaviors, and physiological responses interact to influence suffering and functioning. Although CBT does not

eliminate pain, it helps individuals respond to pain in ways that reduce distress and improve quality of life.

Many older adults develop patterns of catastrophic thinking after years of living with persistent pain. Thoughts such as “Nothing will ever help,” “My life is over because of this pain,” or “Any activity will make things worse” often contribute to emotional distress and avoidance behaviors. CBT helps individuals identify and modify these patterns while developing more adaptive coping strategies.

In clinical practice, CBT frequently includes activity pacing, behavioral activation, relaxation training, sleep interventions, cognitive restructuring, and problem-solving techniques. These skills help patients increase engagement in meaningful activities while reducing reliance on passive coping strategies. Research supports CBT as an effective intervention for improving pain-related functioning, mood, and quality of life among older adults experiencing chronic pain (Eccleston et al., 2020).

A practical example involves an older adult who has gradually stopped participating in social activities due to pain fears. Rather than encouraging complete rest, CBT helps the individual gradually increase activity levels, challenge fear-based assumptions, and develop confidence in their ability to function despite discomfort.

Acceptance and Commitment Therapy

Acceptance and Commitment Therapy (ACT) has gained substantial empirical support as a treatment for chronic pain and related conditions. ACT differs from traditional symptom-reduction approaches by focusing on psychological flexibility and values-based living. The goal is not to eliminate pain or difficult emotions but to help individuals engage in meaningful activities despite their presence. Older adults often respond positively to ACT because many have experienced pain or

health conditions that cannot be completely resolved. Rather than engaging in an exhausting struggle to eliminate all discomfort, ACT encourages individuals to focus on living consistently with personal values.

For example, an older adult may value maintaining close relationships with grandchildren but avoid family gatherings because of pain concerns. ACT helps the individual clarify this value and develop willingness to experience some discomfort in pursuit of meaningful connection. Over time, this shift often reduces suffering and increases life satisfaction.

Research demonstrates that ACT can improve functioning, reduce pain-related interference, and enhance psychological well-being among individuals with chronic pain conditions (Hughes et al., 2017). For many older adults, the emphasis on acceptance, flexibility, and meaning aligns naturally with developmental processes associated with aging.

Motivational Interviewing

Motivational Interviewing (MI) is a collaborative, client-centered approach designed to strengthen an individual's intrinsic motivation for change. Although initially developed for substance use disorders, MI has become a widely used intervention across healthcare settings, particularly when clients experience ambivalence regarding treatment recommendations or behavioral change. Older adults with opioid-related concerns often present with mixed feelings about medication reduction, lifestyle modifications, physical activity, or engagement in behavioral treatment. MI provides a respectful and effective framework for exploring these concerns while supporting autonomy and self-determination.

One of the strengths of MI is its emphasis on partnership rather than persuasion. Older adults may have longstanding experiences with healthcare systems and may become resistant when they perceive providers as dismissive, paternalistic, or

overly directive. MI helps psychologists explore both the benefits and drawbacks of current behaviors while eliciting the individual's own reasons for change. This process often leads to greater engagement and more sustainable outcomes.

In practice, a psychologist might work with an older adult who acknowledges concerns about long-term opioid use but fears that reducing medication will result in unbearable pain. Rather than arguing for medication reduction, the psychologist explores the patient's goals, concerns, and values. Through reflective listening and strategic questioning, the patient may begin to identify discrepancies between current behaviors and desired outcomes, creating motivation for gradual change.

Behavioral Activation

Behavioral Activation (BA) is particularly valuable for older adults who experience depression, social withdrawal, inactivity, and reduced engagement in meaningful activities. Chronic pain and opioid-related concerns frequently contribute to cycles of avoidance in which individuals reduce activity levels in an effort to prevent discomfort. Although this strategy may provide short-term relief, it often leads to worsening physical deconditioning, increased disability, social isolation, and depressive symptoms.

Behavioral Activation focuses on increasing participation in meaningful and rewarding activities. Rather than waiting for motivation to return, individuals are encouraged to take small, structured steps toward re-engagement. These activities are selected collaboratively and are tailored to the individual's interests, abilities, and values.

For example, an older adult who previously enjoyed gardening but stopped participating because of pain may begin with brief periods of outdoor activity several times per week. Another individual who has become socially isolated may

gradually resume attending community events or reconnecting with friends. These interventions help restore a sense of purpose and accomplishment while reducing the emotional burden associated with chronic pain.

Behavioral Activation can effectively reduce depressive symptoms and improve functioning among older adults (Orgeta et al., 2017). Because depression is a common comorbidity among individuals with chronic pain and opioid-related concerns, BA often serves as an important component of comprehensive treatment.

Mindfulness-Based Interventions

Mindfulness-based interventions have received increasing attention as complementary approaches for chronic pain management and opioid-related concerns. These interventions focus on developing present-moment awareness, nonjudgmental observation of internal experiences, and improved emotional regulation. Rather than attempting to eliminate pain or distressing thoughts, mindfulness encourages individuals to change their relationship with these experiences.

Many older adults describe becoming trapped in cycles of worry, frustration, and anticipatory fear regarding pain. These cognitive and emotional reactions often amplify suffering and contribute to avoidance behaviors. Mindfulness-based interventions help individuals observe sensations, thoughts, and emotions without automatically reacting to them.

Mindfulness-Based Stress Reduction (MBSR) and Mindfulness-Based Cognitive Therapy (MBCT) are among the most widely studied approaches. Techniques commonly include breathing exercises, body scans, guided meditation, mindful movement, and awareness practices that can be adapted to accommodate physical limitations. Research suggests that mindfulness interventions can reduce

pain-related distress, improve emotional functioning, and enhance quality of life among individuals experiencing chronic pain (Hilton et al., 2017). A practical example involves an older adult who experiences intense anxiety whenever pain increases. Through mindfulness training, the individual learns to observe pain sensations without immediately catastrophizing or engaging in avoidance. Over time, this approach can reduce emotional reactivity and improve coping effectiveness.

Integrated Treatment for Co-Occurring Mental Health Conditions

Many older adults with opioid-related concerns experience co-occurring mental health conditions that significantly influence treatment outcomes. Depression, anxiety disorders, trauma-related symptoms, complicated grief, insomnia, and adjustment difficulties frequently interact with chronic pain and opioid use. Treating these conditions separately often leads to fragmented care and missed opportunities for intervention.

Integrated treatment recognizes the interconnected nature of physical, emotional, and behavioral health. Psychologists should routinely assess for mental health concerns and incorporate appropriate interventions into treatment planning. Addressing depression may improve pain coping, while reducing anxiety can increase willingness to participate in physical rehabilitation and behavioral activation.

For example, an older adult struggling with chronic pain following the death of a spouse may experience worsening depression, reduced activity levels, disrupted sleep, and increasing reliance on opioid medication. A comprehensive treatment plan might combine grief-focused therapy, CBT strategies, behavioral activation, sleep interventions, and coordination with medical providers. This integrated

approach addresses the multiple factors contributing to distress rather than focusing exclusively on pain or medication use.

Research supports integrated behavioral healthcare models for individuals with chronic pain and substance-related concerns (National Academies of Sciences, Engineering, and Medicine [NASEM], 2019). These approaches improve communication among providers, enhance continuity of care, and support more comprehensive treatment planning.

Adapting Psychological Interventions for Older Adults

Although evidence-based treatments provide valuable frameworks, psychologists must adapt interventions to meet the needs of older adults. Sensory impairments, cognitive changes, physical limitations, cultural factors, educational background, and medical complexity can all influence treatment delivery.

Interventions may need to proceed at a slower pace, incorporate repetition of key concepts, or include written materials to support retention. Visual impairments may require larger print materials, while hearing difficulties may necessitate adjustments in communication style. Psychologists should also consider generational attitudes toward mental health treatment, pain, and substance use when developing treatment plans.

Family involvement can be particularly helpful when appropriate and consistent with the patient's preferences. Caregivers often assist with treatment adherence, reinforce coping strategies, and support behavioral change efforts. At the same time, psychologists must remain attentive to issues of autonomy, confidentiality, and informed consent.

Cultural considerations are equally important. Beliefs about pain, aging, medication use, mental health treatment, and healthcare providers vary

substantially across cultural groups. Effective treatment requires cultural humility and a willingness to understand each individual's unique experiences and perspectives.

Clinical Case Example

Mr. L was a 72-year-old retired teacher referred for psychological treatment following concerns about increasing opioid reliance for chronic neuropathic pain. During the initial evaluation, he reported significant social withdrawal, poor sleep, reduced physical activity, and symptoms of depression. He expressed fear that any increase in activity would worsen his pain and stated that medication was the only thing that allowed him to function.

Treatment incorporated CBT, Behavioral Activation, and Motivational Interviewing strategies. Early sessions focused on exploring Mr. L's goals and increasing awareness of the relationship between avoidance, depression, and pain-related disability. Behavioral Activation was used to gradually reintroduce meaningful activities, including walking with friends and volunteering at a local library. CBT interventions targeted catastrophic thinking patterns and helped him develop more balanced appraisals of pain-related experiences.

Over several months, Mr. L demonstrated improved mood, increased activity participation, and greater confidence in managing discomfort without relying exclusively on medication. Although pain remained present, its impact on daily functioning decreased significantly. This case illustrates how evidence-based psychological interventions can improve quality of life even when pain symptoms persist.

Summary

Psychological interventions represent a critical component of comprehensive care for older adults experiencing opioid-related concerns. Cognitive Behavioral Therapy, Acceptance and Commitment Therapy, Motivational Interviewing, Behavioral Activation, mindfulness-based interventions, and integrated treatment approaches all offer evidence-based strategies for improving functioning, reducing distress, and enhancing quality of life.

Effective treatment extends beyond pain reduction and focuses on helping individuals live meaningful, engaged lives despite ongoing health challenges. By addressing the cognitive, emotional, behavioral, and social dimensions of chronic pain and opioid use, psychologists can support safer treatment, improved functioning, and long-term well-being among older adults.

Section 8: Supporting Adherence and Self-Management in Older Adults With Opioid-Related Concerns

Introduction

One of the greatest challenges in working with older adults who experience chronic pain and opioid-related concerns is supporting long-term treatment adherence and effective self-management. Even the most carefully developed treatment plan will have limited effectiveness if an individual is unable or unwilling to follow recommendations consistently. Older adults often face unique barriers that complicate adherence, including cognitive changes, sensory impairments, transportation difficulties, financial constraints, complex medication regimens, social isolation, and multiple chronic health conditions. Psychologists

are uniquely positioned to identify these barriers and help patients develop practical strategies that support treatment engagement and long-term health outcomes.

Adherence should not be viewed simply as compliance with medical recommendations. Contemporary healthcare models emphasize collaborative self-management, in which patients actively participate in treatment decisions, develop confidence in their ability to manage symptoms, and engage in behaviors that support physical and psychological well-being. For older adults living with chronic pain, successful self-management often requires balancing medication use, physical activity, behavioral coping skills, medical appointments, social engagement, and management of co-occurring mental health concerns. Psychological interventions can help individuals build these skills while addressing emotional and behavioral obstacles that interfere with treatment success.

Understanding Barriers to Adherence

Treatment adherence among older adults is influenced by a complex interaction of cognitive, emotional, social, medical, and environmental factors. While some individuals intentionally choose not to follow treatment recommendations, nonadherence is often unintentional and reflects practical challenges rather than resistance. Understanding the reasons behind nonadherence is therefore essential before attempting intervention.

Cognitive changes are among the most common contributors to adherence difficulties. Even mild deficits in memory, attention, or executive functioning can affect an individual's ability to follow complex medication schedules, remember appointments, or implement behavioral recommendations. Older adults with mild cognitive impairment may appear highly functional during brief clinical encounters

while experiencing significant challenges managing treatment independently at home.

Emotional factors also play a substantial role. Depression may reduce motivation, energy, and organizational abilities, making it difficult to maintain treatment routines. Anxiety may contribute to avoidance of healthcare appointments or excessive worry regarding medication side effects. Chronic pain itself can undermine adherence by increasing frustration, hopelessness, and perceptions that treatment efforts are ineffective.

Social determinants of health further influence treatment engagement. Limited transportation, financial hardship, inadequate social support, unstable housing, and healthcare access barriers may all interfere with adherence. Psychologists should assess these factors routinely and incorporate them into treatment planning rather than focusing exclusively on individual-level behavior change.

Promoting Medication Adherence and Safety

Medication adherence is particularly important for older adults prescribed opioid medications or medications for opioid use disorder (MOUD). Difficulties with adherence can result in inadequate symptom control, withdrawal symptoms, increased risk of adverse events, or unintentional overdose. At the same time, overadherence, such as taking medications more frequently than prescribed, may also create substantial safety concerns.

Assessment should include detailed exploration of medication management practices. Psychologists should inquire about how medications are organized, whether reminders are used, who assists with medication management, and whether patients have experienced missed doses, confusion, or difficulties understanding instructions. Open-ended questions often yield more accurate information than simple yes-or-no inquiries.

Behavioral strategies can substantially improve medication adherence. Pill organizers, medication reminder systems, smartphone alerts, written schedules, and caregiver involvement are commonly used interventions. For individuals with cognitive limitations, simplifying routines and reducing complexity whenever possible may improve success. Psychologists can collaborate with prescribing providers and family members to identify practical solutions that fit the individual's needs and preferences.

Psychoeducation is equally important. Many older adults receive limited information regarding medication interactions, safe storage practices, disposal procedures, and overdose risk. Providing clear, understandable education can increase confidence and improve adherence while promoting safer medication use.

Self-Efficacy and Health Behavior Change

A key concept underlying successful self-management is self-efficacy, defined as an individual's belief in their ability to perform specific behaviors and achieve desired outcomes. Older adults who feel overwhelmed by pain, medical conditions, or functional limitations often develop low self-efficacy and may become increasingly passive in managing their health.

Psychologists can help patients strengthen self-efficacy by focusing on achievable goals, reinforcing progress, and highlighting existing strengths. Small successes often build confidence and create momentum for larger behavioral changes. For example, an individual who successfully incorporates brief daily walks may become more willing to engage in additional self-management activities over time.

Motivational interviewing techniques can be particularly useful in fostering self-efficacy. Rather than directing patients toward specific behaviors, psychologists

help individuals identify personal reasons for change and recognize their own capabilities. This collaborative approach promotes autonomy and encourages sustained engagement.

Behavioral Strategies for Chronic Pain Self-Management

Effective self-management requires more than medication adherence. Older adults benefit from learning behavioral strategies that allow them to manage symptoms proactively and maintain functioning despite ongoing pain or health challenges. Psychologists frequently teach techniques that reduce distress while promoting adaptive coping.

Activity pacing is one of the most commonly recommended strategies. Many individuals alternate between periods of excessive activity and prolonged rest, creating cycles that worsen pain and fatigue. Activity pacing encourages a more balanced approach in which activities are distributed throughout the day and adjusted to match current abilities.

Sleep hygiene interventions can also improve functioning and symptom management. Poor sleep is strongly associated with increased pain sensitivity, emotional distress, cognitive difficulties, and reduced quality of life. Education regarding sleep schedules, environmental factors, and behavioral habits can significantly improve sleep quality and overall well-being.

Stress management techniques such as relaxation training, diaphragmatic breathing, mindfulness practices, and guided imagery may further support self-management efforts. These approaches help individuals regulate emotional responses to pain while improving coping effectiveness and reducing physiological arousal.

The Role of Family and Caregivers

Family members and caregivers often play an essential role in supporting treatment adherence among older adults. They may assist with medication management, transportation, appointment scheduling, communication with healthcare providers, and monitoring for signs of deterioration or safety concerns. Their involvement can be particularly important when cognitive impairment or functional limitations are present.

Psychologists should assess caregiver resources, stress levels, and support needs as part of routine clinical care. Caregiver burden is common and may negatively affect both the caregiver and the patient if not addressed appropriately. Education regarding pain management, medication safety, communication strategies, and realistic expectations can improve outcomes for everyone involved. At the same time, clinicians must remain attentive to issues of autonomy and self-determination. Older adults should be included in decision-making to the greatest extent possible, and family involvement should occur in a manner consistent with patient preferences and ethical standards.

Summary

Supporting adherence and self-management requires psychologists to look beyond medication use and consider the broader context of an older adult's daily life. Cognitive functioning, emotional well-being, social support, health literacy, self-efficacy, and environmental factors all influence treatment engagement and long-term outcomes.

By helping patients develop practical skills, strengthen confidence, overcome barriers, and access appropriate supports, psychologists can significantly improve adherence, reduce risk, and promote greater independence and quality of life among older adults experiencing opioid-related concerns.

Section 9: Interdisciplinary Collaboration and Integrated Care for Older Adults With Opioid-Related Concerns

Introduction

Older adults experiencing chronic pain, opioid-related concerns, opioid use disorder, or co-occurring medical and mental health conditions rarely receive care from a single provider. Instead, treatment often occurs across multiple healthcare settings and involves numerous professionals with distinct roles and expertise. As healthcare systems become increasingly complex, interdisciplinary collaboration has become an essential component of effective care. Psychologists must understand how to function within integrated healthcare teams while maintaining professional identity, ethical standards, and a patient-centered approach.

The need for interdisciplinary collaboration is particularly pronounced among older adults because aging is frequently accompanied by multiple chronic health conditions, increased healthcare utilization, functional limitations, and social service needs. Effective treatment requires coordination among medical providers, behavioral health clinicians, pharmacists, rehabilitation specialists, social workers, caregivers, and community organizations. Without communication and collaboration, treatment plans may become fragmented, inconsistent, or even contradictory, increasing the risk of adverse outcomes.

Psychologists contribute a unique perspective to interdisciplinary teams by helping providers understand the psychological, behavioral, cognitive, and social factors that influence pain, substance use, treatment adherence, decision-making, and overall functioning. Their expertise enhances assessment, treatment planning, patient engagement, and long-term outcome monitoring.

The Biopsychosocial Foundation of Integrated Care

As discussed in Section 4, the biopsychosocial model provides the conceptual foundation for this work. In an interdisciplinary setting, this model determines how responsibilities are divided across team members.

Integrated care seeks to address these multiple dimensions simultaneously. Psychologists help ensure that treatment planning reflects the full complexity of each patient's circumstances rather than focusing narrowly on symptom management. This broader perspective often leads to more effective and sustainable outcomes.

Key Members of the Interdisciplinary Team

Primary care providers frequently serve as the central coordinators of care for older adults. They manage chronic medical conditions, monitor medications, and often identify emerging concerns related to pain, substance use, or mental health. Psychologists commonly collaborate with primary care providers regarding assessment findings, treatment recommendations, and behavioral health interventions.

Pain management specialists contribute expertise regarding complex pain conditions, interventional procedures, medication management, and multidisciplinary treatment planning. Psychologists often work alongside these providers to address pain-related beliefs, coping strategies, and behavioral factors influencing treatment outcomes.

Pharmacists play an increasingly important role in opioid-related care. Their knowledge of medication interactions, dosing considerations, adverse effects, and medication safety is particularly valuable when working with older adults

experiencing polypharmacy. Collaboration with pharmacists can help identify medication-related risks before significant complications occur.

Social workers assist with resource coordination, caregiver support, housing concerns, transportation barriers, insurance issues, and access to community services. Because social determinants of health strongly influence treatment adherence and recovery, social workers are often critical members of the care team.

Nurses, physical therapists, occupational therapists, addiction specialists, and geriatricians may also contribute specialized expertise depending on the individual's needs. Effective collaboration requires respect for each professional's role while maintaining a shared focus on patient well-being.

Communication in Interdisciplinary Practice

Effective communication is the cornerstone of successful interdisciplinary care. Even highly skilled providers may struggle to achieve positive outcomes if information is not shared accurately and efficiently. Psychologists must be able to communicate assessment findings and treatment recommendations in ways that are clinically meaningful and accessible to professionals from other disciplines.

Written documentation should be concise, clear, and focused on information relevant to patient care. Excessive psychological jargon may reduce the usefulness of reports for medical providers. Instead, psychologists should emphasize practical implications, behavioral observations, treatment recommendations, and identified risk factors.

Verbal communication is equally important. Case conferences, interdisciplinary meetings, consultation calls, and informal discussions often provide opportunities to coordinate care and resolve concerns. Psychologists should be prepared to

explain psychological concepts in language that promotes understanding and collaboration.

Maintaining professionalism during disagreements is also essential. Differences in clinical opinion are inevitable within interdisciplinary settings. Effective teams address these differences respectfully while keeping patient welfare as the primary consideration.

Integrated Care for Opioid Use Disorder

Integrated care models are particularly beneficial for older adults with opioid use disorder because treatment frequently involves both behavioral and medical interventions. Medications for opioid use disorder (MOUD), including buprenorphine, methadone, and naltrexone, are often most effective when combined with psychological support and ongoing monitoring.

Psychologists contribute by addressing factors that influence recovery, including depression, anxiety, trauma, grief, chronic pain, sleep disturbance, social isolation, and cognitive impairment. These concerns often affect treatment retention, medication adherence, and relapse risk.

Integrated care also facilitates early identification of emerging problems. A psychologist may notice increasing depressive symptoms, while a physician identifies medication-related concerns and a social worker becomes aware of housing instability. When information is shared effectively, interventions can be coordinated before problems escalate.

Research supports integrated behavioral health approaches for individuals with substance use disorders and co-occurring medical conditions (National Academies of Sciences, Engineering, and Medicine, 2019). Older adults often derive particular benefit because of the complexity of their healthcare needs.

Working With Families and Caregivers

Family members and caregivers frequently function as informal members of the interdisciplinary team. They often provide information regarding daily functioning, medication adherence, behavioral changes, and treatment engagement that may not be readily apparent during clinical encounters.

Psychologists can help caregivers understand treatment goals, recognize warning signs, support behavior change, and navigate healthcare systems. Education regarding opioid safety, overdose prevention, cognitive impairment, and chronic pain management is often beneficial. At the same time, clinicians must balance family involvement with patient autonomy and confidentiality. Clear communication regarding consent, information sharing, and decision-making responsibilities helps prevent misunderstandings and promotes effective collaboration.

Summary

Interdisciplinary collaboration is essential when working with older adults experiencing opioid-related concerns. Psychologists contribute valuable expertise regarding behavioral health, cognition, motivation, coping, adherence, and psychosocial functioning. Through effective communication and integrated care planning, interdisciplinary teams can address the complex factors influencing pain, substance use, recovery, and overall quality of life.

As healthcare systems continue to evolve, psychologists must remain prepared to work collaboratively across disciplines while advocating for comprehensive, patient-centered care.

Section 10: Ethical and APA Practice Considerations

Introduction

Psychologists working with older adults who experience chronic pain, opioid use disorder (OUD), opioid misuse, or other opioid-related concerns must navigate a variety of ethical and professional issues that arise in clinical practice. Although many ethical principles apply broadly across psychological services, older adults often present with unique challenges involving informed consent, decision-making capacity, confidentiality, family involvement, risk management, documentation, and interdisciplinary care. These issues become even more complex when opioid medications, chronic medical conditions, cognitive impairment, or substance use disorders are involved.

Ethical practice requires more than simply following rules or regulations. Psychologists must integrate ethical principles, professional standards, clinical judgment, and patient-centered care into every aspect of assessment and treatment. The American Psychological Association (APA) Ethical Principles of Psychologists and Code of Conduct provides an essential framework for addressing these issues while promoting beneficence, nonmaleficence, autonomy, fidelity, integrity, and justice (American Psychological Association [APA], 2017).

For older adults with opioid-related concerns, ethical practice often requires balancing competing priorities. Clinicians may need to protect patient safety while respecting autonomy, maintain confidentiality while involving caregivers appropriately, or address risks without contributing to stigma. Developing competence in these areas is critical for psychologists working in healthcare, private practice, integrated care, and community settings.

Professional Competence and Scope of Practice

APA Ethics Code Standard 2.01 requires psychologists to provide services within the boundaries of their competence, based on education, training, supervised experience, consultation, study, or professional experience (APA, 2017). This principle is particularly relevant when working with older adults who present with complex combinations of chronic pain, opioid use, cognitive impairment, psychiatric disorders, and medical conditions.

Psychologists should not assume that expertise in one area automatically translates to competence in another. For example, a clinician experienced in treating depression may require additional training before conducting assessments involving opioid misuse, medication-assisted treatment, or cognitive disorders associated with aging. Similarly, psychologists working primarily with substance use disorders may benefit from specialized education regarding geropsychology, chronic pain, and age-related cognitive changes.

Competence also requires ongoing professional development. The fields of pain management, addiction treatment, and geriatric healthcare continue to evolve rapidly. New research findings, treatment guidelines, medications, and healthcare delivery models emerge regularly. Psychologists have an ethical responsibility to remain informed about current evidence-based practices and developments relevant to their work.

Informed Consent and Shared Decision-Making

Informed consent is an ongoing process rather than a single event. Older adults should receive information regarding the nature and purpose of services, potential risks and benefits, confidentiality limits, alternatives to treatment, and the voluntary nature of participation. Information should be presented in a

manner that is understandable and appropriate to the individual's cognitive abilities, educational background, language preferences, and sensory needs.

Working with older adults requires particular attention to communication. Hearing impairment, visual limitations, health literacy concerns, and cognitive changes may affect comprehension. Psychologists should routinely assess understanding rather than assuming that information has been adequately understood because it was presented.

Shared decision-making has become an important component of contemporary healthcare ethics. This approach recognizes that treatment decisions should reflect both clinical expertise and patient preferences. For older adults experiencing chronic pain or opioid-related concerns, shared decision-making promotes autonomy while encouraging active participation in care planning.

Psychologists should encourage patients to ask questions, express concerns, and identify treatment goals that are personally meaningful. When family members or caregivers are involved, clinicians must ensure that the patient's voice remains central to the decision-making process whenever possible.

Decision-Making Capacity and Cognitive Impairment

Questions regarding decision-making capacity frequently arise when working with older adults. Capacity is a clinical determination regarding an individual's ability to make a specific decision at a particular point in time. It is not synonymous with age, diagnosis, or disability.

Individuals with mild cognitive impairment or early-stage dementia may retain the ability to make many healthcare decisions while requiring support in other areas. Conversely, acute medical illness, delirium, intoxication, severe depression, or

medication effects may temporarily impair decision-making in individuals without a diagnosed neurocognitive disorder.

Clinical assessment of capacity generally focuses on four abilities: understanding relevant information, appreciating the consequences of decisions, reasoning through available options, and communicating a consistent choice (Moye & Marson, 2019). Psychologists may be asked to evaluate capacity in situations involving opioid treatment decisions, medication management, living arrangements, healthcare proxies, or consent for treatment.

Ethically sound practice requires avoiding assumptions based solely on age or diagnosis. Capacity assessments should be individualized, evidence-based, and focused on the specific decision under consideration.

Confidentiality and Family Involvement

Confidentiality is a cornerstone of psychological practice and is protected through both ethical standards and legal requirements. However, confidentiality issues can become complex when working with older adults who rely on family members, caregivers, or healthcare teams for support.

Many older adults want family members involved in aspects of their care. Others prefer greater privacy. Psychologists should clarify patient preferences early in treatment and obtain appropriate authorization before sharing information whenever possible.

Challenges often arise when family members express concerns regarding medication use, cognitive decline, safety risks, or treatment adherence. While caregivers frequently provide valuable collateral information, psychologists must carefully balance the benefits of information sharing with ethical obligations to protect confidentiality.

Clear communication regarding the limits of confidentiality and the circumstances under which information may be disclosed can help prevent misunderstandings. Documentation of these discussions is also important from both ethical and risk-management perspectives.

Documentation and Record Keeping

Accurate documentation is an essential component of ethical and professional practice. Clinical records support continuity of care, facilitate communication among providers, document clinical reasoning, and provide evidence of professional decision-making.

Documentation involving opioid-related concerns should be thorough, objective, and behaviorally specific. Records should include assessment findings, treatment plans, informed consent discussions, risk assessments, consultations, recommendations, and follow-up actions. When concerns regarding medication misuse, overdose risk, suicidality, or cognitive impairment arise, documentation should clearly reflect the rationale for clinical decisions.

Electronic health records have increased opportunities for interdisciplinary communication but also create additional responsibilities related to privacy, access control, and information sharing. Psychologists must remain familiar with organizational policies and applicable legal requirements governing documentation practices.

Ethical Management of Risk

Risk management is a central component of clinical work with older adults experiencing opioid-related concerns. Psychologists may encounter situations

involving overdose risk, medication misuse, suicidal ideation, cognitive decline, self-neglect, elder abuse, or impaired decision-making.

Ethically sound risk management begins with comprehensive assessment. Clinicians should evaluate both risk factors and protective factors while recognizing that risk exists on a continuum rather than as a simple present-or-absent phenomenon. Ongoing monitoring is often necessary because risk levels may fluctuate over time.

When significant concerns emerge, psychologists should take reasonable steps to reduce foreseeable harm. These actions may include safety planning, consultation, referral, communication with other providers, involvement of support systems, or emergency intervention when warranted. Decisions should be guided by clinical judgment, ethical principles, legal requirements, and the patient's circumstances. Importantly, ethical risk management does not require eliminating all risk. Instead, psychologists seek to identify, understand, and manage risks in a manner that supports both safety and autonomy.

Summary

Ethical practice with older adults experiencing opioid-related concerns requires careful attention to competence, informed consent, capacity, confidentiality, documentation, risk management, and stigma reduction. Psychologists must integrate professional standards with clinical judgment while respecting patient autonomy and promoting safety.

By maintaining ethical awareness and engaging in ongoing professional development, psychologists can navigate complex clinical situations effectively while providing compassionate, evidence-based care to older adults and their families.

Section 11: Cultural Competence and Diversity

Considerations in Older Adults With Opioid-Related Concerns

Introduction

Cultural competence is an essential component of ethical and effective psychological practice. Older adults are not a homogeneous group, and experiences related to pain, aging, opioid use, healthcare access, mental health treatment, and recovery are influenced by cultural identity, life experiences, socioeconomic status, language, religion, geographic location, sexual orientation, gender identity, and numerous other factors. Psychologists working with older adults experiencing opioid-related concerns must recognize how these variables shape assessment, treatment engagement, healthcare experiences, and outcomes.

Historically, discussions regarding opioid use and chronic pain have often focused on medical and behavioral factors while giving less attention to cultural influences. However, research increasingly demonstrates that disparities exist across racial, ethnic, socioeconomic, and geographic groups in areas such as pain assessment, opioid prescribing, access to treatment, and healthcare quality (Lagisetty et al., 2019). Understanding these disparities is critical for psychologists seeking to provide equitable and culturally responsive care.

Cultural competence is not achieved through memorization of cultural traits or assumptions about specific groups. Rather, it involves ongoing self-reflection, cultural humility, awareness of systemic influences, and a commitment to understanding each individual's unique experiences and perspectives.

Cultural Beliefs About Pain and Aging

Beliefs regarding pain and aging vary significantly across cultural groups and may influence how older adults describe symptoms, seek treatment, and respond to interventions. Some individuals view pain as an expected part of aging and may be reluctant to discuss symptoms or pursue treatment. Others may interpret pain through spiritual, religious, or family-centered frameworks that shape coping behaviors and healthcare decisions.

Psychologists should avoid making assumptions regarding pain experiences based solely on cultural background. Instead, clinicians should explore how patients understand their symptoms, what meaning they assign to pain, and what strategies they have used to cope. These discussions often reveal important information that may influence treatment planning.

Cultural beliefs may also affect attitudes toward opioid medications. Some individuals express significant concerns regarding addiction, dependence, or stigma, while others may place strong trust in medical recommendations. Understanding these perspectives allows psychologists to tailor psychoeducation and interventions more effectively.

Racial and Ethnic Disparities in Pain and Substance Use Treatment

Research has documented persistent disparities in pain assessment and treatment across racial and ethnic groups. Historically marginalized populations often experience barriers to healthcare access, delayed treatment, reduced access to specialty care, and differences in pain management practices. These disparities are influenced by structural factors, implicit bias, socioeconomic conditions, and historical experiences with healthcare systems (Lagisetty et al., 2019).

Older adults from historically marginalized communities may approach healthcare interactions with understandable caution, particularly if previous experiences involved discrimination or inadequate treatment. Establishing trust therefore becomes an essential component of effective care. Psychologists should be aware that disparities may also affect access to opioid use disorder treatment. Medications for opioid use disorder, specialty addiction services, and integrated behavioral healthcare are not equally available across communities. Clinicians should assess barriers to care and advocate for equitable access whenever possible.

Rural Communities and Healthcare Access

Older adults living in rural communities often face unique challenges related to opioid-related care. Geographic isolation, transportation difficulties, healthcare workforce shortages, limited specialty services, and stigma surrounding mental health treatment may reduce access to care.

These barriers can have significant implications for chronic pain management, substance use treatment, and psychological services. In some areas, older adults may need to travel considerable distances to access specialty providers or medication-assisted treatment programs.

Telehealth has emerged as an important strategy for addressing these disparities. Research suggests that telehealth can improve access to behavioral health services and support continuity of care for individuals living in underserved areas (Totten et al., 2022). However, digital access limitations and varying levels of technological familiarity must also be considered.

Psychologists working with rural populations should adopt flexible approaches that account for transportation challenges, healthcare availability, and community resources.

LGBTQ+ Older Adults

LGBTQ+ older adults represent a diverse population with unique strengths, experiences, and healthcare needs. Many have lived through periods of significant discrimination and may carry concerns regarding stigma within healthcare settings. These experiences can influence willingness to seek treatment, disclose personal information, or engage with providers.

Research suggests that LGBTQ+ older adults experience elevated rates of social isolation, discrimination, mental health concerns, and barriers to healthcare access compared with some heterosexual and cisgender peers (Fredriksen-Goldsen et al., 2017). These factors may influence pain experiences, substance use risk, and treatment engagement.

Psychologists should create affirming clinical environments by using inclusive language, avoiding assumptions regarding identity or relationships, and demonstrating cultural humility. Small actions, such as asking about preferred names and pronouns or acknowledging diverse family structures, can significantly enhance therapeutic rapport. Importantly, clinicians should balance awareness of risk factors with recognition of resilience. Many LGBTQ+ older adults possess substantial strengths, coping resources, and supportive communities that contribute positively to health and well-being.

Socioeconomic Factors and Social Determinants of Health

Social determinants of health exert profound effects on opioid-related outcomes among older adults. Income, education, housing stability, food security, transportation access, and healthcare affordability all influence treatment engagement and recovery.

Financial strain may affect an individual's ability to obtain medications, attend appointments, access specialty care, or participate in recommended activities. Housing instability and caregiver limitations may further complicate treatment adherence and safety.

Psychologists should routinely assess these factors as part of comprehensive clinical evaluations. Interventions focused exclusively on individual behavior may be insufficient when significant structural barriers exist. Collaboration with social workers, case managers, community organizations, and healthcare systems can help address these broader influences. A culturally responsive approach recognizes that many treatment challenges arise not from lack of motivation but from barriers embedded within social and healthcare systems.

Cultural Humility in Clinical Practice

Cultural humility provides a useful framework for working with diverse populations. Unlike traditional models that emphasize acquiring knowledge about specific groups, cultural humility emphasizes lifelong learning, self-reflection, openness, and recognition of power differences within healthcare relationships.

Psychologists should examine their own assumptions regarding aging, pain, substance use, race, ethnicity, gender, sexual orientation, disability, and socioeconomic status. Awareness of personal biases helps reduce the likelihood that these beliefs will negatively influence clinical decision-making.

Culturally responsive assessment involves asking questions rather than making assumptions. Clinicians should explore how cultural identity influences healthcare experiences, treatment preferences, family involvement, and perceptions of recovery. This individualized approach promotes more accurate assessment and more effective intervention planning.

Medicare Coverage and Access Considerations

Because most adults age 65 and older are Medicare beneficiaries, psychologists should understand how Medicare coverage can influence access to opioid-related treatment. Medicare covers a range of services for opioid use disorder (OUD), but coverage depends on the type of service, treatment setting, and component of Medicare involved. Medicare Part B covers OUD treatment delivered through Medicare-enrolled Opioid Treatment Programs (OTPs), including medications for OUD, individual and group therapy, substance use counseling, toxicology testing, periodic assessments, care coordination, peer recovery services, and overdose education. Medicare also covers office-based behavioral health and substance use treatment services when applicable. Importantly, Medicare coverage of OTP services includes methadone, which is an important consideration because methadone for OUD is generally administered through federally certified OTPs rather than routinely prescribed through traditional outpatient medical practices (Centers for Medicare & Medicaid Services [CMS], 2026).

Medication coverage can be more complicated. Medicare Part B covers medications such as methadone, buprenorphine, and naltrexone when they are furnished through qualifying settings such as an OTP, while Medicare Part D may cover outpatient medications such as buprenorphine and naltrexone. Naloxone and other opioid-overdose reversal medications may also be covered through Medicare, although the specific coverage pathway can depend on where and how the medication is obtained. Part D formularies, utilization-management requirements, pharmacy networks, and differences among Medicare Advantage plans can create practical barriers even when a treatment is technically covered. Cost sharing can also vary by service and setting. For example, beneficiaries receiving OUD services through a Medicare-enrolled OTP generally do not have a copayment for those OTP services, although the Part B deductible applies;

services obtained through other outpatient providers may involve Part B deductibles and coinsurance (CMS, 2026).

For psychologists, Medicare status should therefore be considered as part of the broader assessment of treatment access rather than merely as an insurance detail. When recommending psychotherapy, addiction treatment, medication evaluation, naloxone, or a higher level of care, psychologists should consider whether the recommended provider participates in Medicare, whether an appropriate Medicare-enrolled OTP is geographically accessible, and whether the patient's specific Medicare or Medicare Advantage plan creates additional coverage or network requirements. Psychologists can also help older patients and families navigate these barriers through care coordination with prescribers, pharmacists, social workers, case managers, and treatment programs (CMS, 2026).

Summary

Cultural competence and cultural humility are essential components of effective psychological practice with older adults experiencing opioid-related concerns. Pain, substance use, healthcare access, and recovery are shaped by cultural, social, historical, and economic influences that vary across individuals and communities.

By recognizing diversity, addressing disparities, examining personal biases, and engaging in culturally responsive care, psychologists can improve assessment accuracy, strengthen therapeutic relationships, and promote more equitable health outcomes for older adults.

Section 12: Case Studies and Practical Applications

Introduction

Knowledge of opioid-related concerns in older adults becomes most valuable when clinicians can apply assessment, intervention, ethical decision-making, and interdisciplinary collaboration principles to real-world situations. Older adults rarely present with isolated problems. Instead, psychologists frequently encounter complex clinical scenarios involving chronic pain, multiple medical conditions, cognitive changes, social stressors, mental health concerns, and opioid-related risks. Effective clinical practice requires integrating information from multiple sources while balancing patient autonomy, safety, and evidence-based care.

The following case examples illustrate how psychologists can apply the concepts discussed throughout this course. These cases are not intended to represent all possible clinical situations but rather demonstrate common challenges encountered in practice. Particular attention is given to assessment, treatment planning, interdisciplinary collaboration, cultural responsiveness, and ethical decision-making.

Case Study 1: Chronic Pain, Depression, and Escalating Opioid Use

Mrs. T was a 72-year-old retired teacher referred for psychological evaluation by her primary care physician. She had a history of chronic osteoarthritis, hypertension, and persistent low back pain. Over the previous year, her opioid dosage had gradually increased due to worsening pain complaints. Although she denied misuse, she reported increasing reliance on medication to cope with emotional distress following the death of her husband.

Assessment revealed significant depressive symptoms, social isolation, sleep disturbance, and reduced engagement in previously enjoyable activities. Cognitive screening did not indicate significant impairment. Mrs. T reported spending most of her time at home and expressed hopelessness regarding her future.

A biopsychosocial conceptualization suggested that emotional distress, grief, inactivity, and social isolation were contributing to increased pain-related disability and opioid reliance. Treatment included Cognitive Behavioral Therapy (CBT), Behavioral Activation, grief-focused interventions, and coordination with her prescribing physician. Over time, Mrs. T gradually resumed social activities, reported improved mood, and demonstrated increased confidence in managing pain through behavioral coping strategies rather than relying exclusively on medication.

This case illustrates the importance of evaluating the psychological and social factors that may contribute to opioid use. Although pain was a legitimate concern, emotional distress played a substantial role in symptom exacerbation and treatment outcomes.

Case Study 2: Mild Cognitive Impairment and Medication Safety

Mr. R was a 79-year-old man referred for evaluation after several episodes of medication confusion. He lived alone and managed multiple chronic health conditions, including diabetes, cardiovascular disease, and neuropathic pain. Family members reported increasing forgetfulness and concerns regarding medication adherence.

Clinical assessment included cognitive screening, functional assessment, collateral interviews, and review of medical records. Findings were consistent with Mild Cognitive Impairment (MCI). Although Mr. R remained independent in basic self-

care activities, he demonstrated difficulty organizing medications, remembering appointments, and following complex treatment instructions.

The treatment plan focused on risk reduction and support rather than loss of independence. Recommendations included use of a medication organizer, written schedules, reminder systems, and increased family involvement. Collaboration with healthcare providers helped simplify medication regimens where possible. Follow-up monitoring was recommended due to the progressive nature of cognitive impairment.

This case highlights the importance of assessing both cognition and daily functioning when evaluating opioid-related concerns in older adults. Medication safety often depends as much on functional abilities as on formal cognitive test performance.

Case Study 3: Opioid Use Disorder and Integrated Care

Mr. L was a 68-year-old veteran receiving treatment for opioid use disorder following years of prescription opioid misuse associated with chronic pain. He also met criteria for major depressive disorder and experienced significant social isolation after retirement.

Treatment occurred within an integrated healthcare setting involving a psychologist, primary care physician, addiction specialist, and social worker. Mr. L received buprenorphine treatment while participating in psychotherapy focused on depression, coping skills, relapse prevention, and social reconnection.

The psychologist worked closely with the treatment team to monitor adherence, assess risk factors, and address barriers to recovery. Behavioral Activation and Motivational Interviewing strategies helped Mr. L gradually increase social

engagement and develop meaningful daily routines. The social worker assisted with transportation barriers and community resources.

After one year, Mr. L remained engaged in treatment, demonstrated improved mood, and reported significant improvements in quality of life. This case demonstrates the effectiveness of interdisciplinary care for older adults with complex medical, psychological, and substance-related concerns.

Case Study 4: Cultural Considerations and Healthcare Mistrust

Mrs. A was a 74-year-old woman referred for behavioral pain management services. During initial sessions, she appeared guarded and reluctant to discuss treatment concerns. Further exploration revealed previous healthcare experiences in which she felt her pain complaints had been minimized and dismissed.

Rather than immediately focusing on symptom management, the psychologist prioritized relationship building, cultural humility, and exploration of healthcare experiences. Treatment incorporated psychoeducation, collaborative goal setting, and acknowledgment of the patient's concerns regarding medical treatment.

As trust developed, Mrs. A became more willing to discuss pain management options and participate in behavioral interventions. She reported feeling respected and heard for the first time in many years. This strengthened therapeutic alliance contributed significantly to treatment engagement.

This case illustrates the importance of cultural responsiveness, trust-building, and recognition of prior healthcare experiences when working with older adults from diverse backgrounds.

Summary

Case-based learning highlights the complexity of opioid-related concerns among older adults. Effective practice requires integration of assessment skills, ethical decision-making, evidence-based interventions, and interdisciplinary collaboration. By applying the principles discussed throughout this course, psychologists can help older adults navigate chronic pain, opioid-related risks, and recovery while promoting safety, autonomy, and quality of life.

Section 13: Future Directions and Emerging Trends in Older Adult Opioid Care

Introduction

The landscape of opioid-related care continues to evolve rapidly. Advances in healthcare delivery, addiction treatment, behavioral medicine, gerontology, and public health are creating new opportunities to improve outcomes for older adults. At the same time, demographic shifts, increasing healthcare complexity, and ongoing concerns regarding opioid misuse and overdose continue to present significant challenges. Psychologists must remain informed about emerging developments to maintain competence and provide evidence-based care.

Older adults represent one of the fastest-growing segments of the population. As life expectancy increases, healthcare professionals are likely to encounter larger numbers of older adults living with chronic pain, multiple medical conditions, and substance-related concerns. Preparing for these changes requires ongoing professional education, interdisciplinary collaboration, and adaptation to evolving standards of care.

Expanding Access to Medications for Opioid Use Disorder

One of the most significant developments in recent years has been increased recognition of the effectiveness of medications for opioid use disorder (MOUD). Historically, older adults have been underrepresented in addiction treatment research and may be less likely to receive evidence-based OUD treatment. Future efforts will likely focus on improving access to age-appropriate services, increasing provider training, and integrating addiction treatment into primary care, geriatric medicine, and behavioral health settings. Psychologists will continue to play an important role in supporting treatment engagement, addressing co-occurring mental health concerns, and reducing stigma associated with substance use disorders.

Advances in Integrated and Collaborative Care

Healthcare systems are increasingly moving toward integrated models that combine medical, behavioral, and social services. These approaches are particularly beneficial for older adults because they address the complex interaction of chronic pain, mental health conditions, medical illness, and functional limitations.

Collaborative care models have demonstrated effectiveness for depression, chronic illness management, and behavioral health integration. Similar approaches are being expanded to address opioid-related concerns and chronic pain management. These models facilitate communication among providers and improve continuity of care. Psychologists working in integrated settings may find increasing opportunities to collaborate with physicians, pharmacists, social workers, physical therapists, and community organizations. Such collaboration enhances the ability to address the full range of factors affecting patient outcomes.

Telehealth and Digital Health Innovations

The expansion of telehealth has transformed access to healthcare services for many older adults. Telepsychology, remote monitoring, digital self-management programs, and virtual consultation services have improved access for individuals who face transportation barriers or reside in underserved areas.

Research suggests that telehealth can effectively support behavioral health treatment, chronic disease management, and recovery services when implemented appropriately (Totten et al., 2022). For older adults, telehealth may reduce travel burden, increase treatment continuity, and facilitate involvement of caregivers and family members.

At the same time, psychologists must remain attentive to digital literacy, technology access, sensory limitations, privacy concerns, and patient preferences. Future developments should emphasize equitable access and user-centered design for older populations.

Addressing Health Disparities

Persistent disparities continue to affect pain treatment, opioid prescribing, access to substance use treatment, and healthcare outcomes. Future progress will depend upon addressing structural barriers that contribute to inequitable care.

Research increasingly emphasizes the importance of culturally responsive care, health equity, and community engagement. Psychologists can contribute by advocating for underserved populations, promoting culturally informed assessment and intervention practices, and participating in efforts to reduce healthcare disparities. Improving equity is not simply a matter of fairness. It is also a critical component of improving public health outcomes and ensuring that evidence-based care is available to all individuals who need it.

Conclusion

Older adults experiencing opioid-related concerns represent a growing and often underserved population. Effective care requires an understanding of aging, chronic pain, substance use disorders, mental health, cognitive functioning, ethics, cultural responsiveness, and interdisciplinary collaboration. Throughout this course, we have explored the many factors that influence assessment, treatment, risk management, and recovery among older adults.

Psychologists play a critical role in addressing these challenges. By integrating evidence-based assessment, behavioral interventions, ethical practice, and collaborative care, psychologists can help older adults achieve improved functioning, greater safety, enhanced quality of life, and meaningful recovery. The future of opioid-related care will continue to evolve, but the fundamental principles of compassionate, patient-centered, and evidence-based practice will remain essential.



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