Teaching Workbook for

Practice with Abusers of Alcohol and Other Substances

Albert Morgan’s Story

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Vignette—Albert Morgan

The following vignette is based on an oral history of substance abuse taken in a single interview by two social work students with an older adult willing to share his story. It is not an intake interview, an assessment, or a psychosocial history. Nor is it a composite of several cases. It is simply one older adult’s personal view of his relationship with alcohol and drugs. Only his name and identifying details have been changed.

Description of Albert Morgan

Albert Morgan is a dark skinned 63-year-old African American male who appears his stated age. He is a short, heavyset gentleman who uses a wooden cane for balance. With a gift for storytelling, he seemed comfortable and relaxed relating his experiences to two social work students. He maintained excellent eye contact, and presented with appropriate affect and an upbeat mood.

Mr. Morgan reported that alcohol and marijuana were his primary drugs of choice. His history of chemical abuse also included cocaine (smoked and snorted), nicotine, and Vicodin and Demerol following a severe auto accident. Mr. Morgan declared that “girls” were a part of his addiction too. He disclosed to the social work students that he has had five marriages and two common law marriages. He further reported that he has 5 children, 3 within a marriage and two others that he acknowledges. He provided for his children “financially when I could, but not emotionally. I was too selfish. I could barely deal with my own problems.”

He currently lives on Social Security in an SRO, following a period of homelessness. He has been sober for 2 1/2 years, participates in several recovery groups, lectures to teens on the dangers of drug use and does volunteer work for a service organization that helps recovering addicts. He has begun to reestablish a relationship with two of his children.

Mr. Morgan’s Story

Mr. Morgan was born in Alabama in the waning days of World War II. His grandfather was a Baptist preacher. Both of his parents were well educated- His father was a college administrator and his mother, whom he adored, was a schoolteacher. His father, however, was an alcoholic, prone to fits of anger and violence while intoxicated. According to Mr. Morgan, his father repeatedly abused his mother and him when “under the influence”. His father died an alcohol related death when Mr. Morgan was 6 years old. His mother remarried a fellow teacher, a gentle caring man who “never raised his voice or hand” and was supportive of Mr. Morgan.
However, Mr. Morgan interpreted his stepfather’s patience and reluctance to discipline him as weakness; he tried instead to “emulate my father.”

At the age of 9, Mr. Morgan began raiding the family liquor cabinet, using alcohol “as a crutch to self medicate” his feelings of anger, abandonment, loss, and especially guilt, as he had wished for his father’s death many times. His rage and anger often led to physical fights, leading his mother to say that he “was going to be just like his father.” By the age of eleven, when his parents were out, he started serving liquor to some older neighborhood kids and began, under their influence, to smoke—“regular cigarettes and weed.”

In high school he smoked as much as 4 packs a day and became a heavy drinker, sometimes drinking until he passed out. His parents seemed unwilling or unable to intervene. Specifically, Mr. Morgan recalled one incident in which his stepfather discovered rolling papers within his possessions. Instead of disciplining him he told him “how to roll a proper joint.”

Mr. Morgan’s mother hoped that he would become a physician. He was an intelligent boy, graduating from high school at the age of 16. In the early 1960’s, at the age of 17, he became the only African American student to be enrolled at a large southern university. Mr. Morgan experienced racism there from students, faculty and administration. It took over a year for the school to find a roommate willing to live with him. He became extremely lonely, but predictably “alcohol was my friend.” His anger towards the discrimination at the university grew, fueled by his unresolved childhood experiences. He drank more. His academic work suffered. He was becoming a very volatile young man. “When I got drunk I fought. I was violent, no ifs, ands and buts about it.” Some of the fights then and later ended in arrests.

Mr. Morgan did not finish college. His drinking and marijuana use began to soar, becoming a chronic and daily habit. Despite these troubles Mr. Morgan managed to land a responsible job as a community organizer and job developer in one of the government funded War on Poverty programs during the late 1960’s. Later he became a housing manager for HUD. In addition to earning promotions and a steady salary, he also made, a lucrative living by dealing drugs, and did so well at it that he was able to buy some rental income properties. Financially he was doing well, even afforded a Cadillac at one point, but his drug habit was growing and now included cocaine, Quaaludes and “other pharmaceuticals.” He often operated automobiles when drunk, which resulted in a number of DWI arrests leading to some convictions.
His double life came to a crashing halt with a devastating car accident. While very drunk, he drove his Cadillac off a cliff into a lake. Miraculously he survived the crash, and rescuers used the Jaws of Life to extract his mangled body from the wreckage. He spent months in the hospital recovering from multiple fractures, including a badly shattered leg. (He still uses a cane when walking). Although he did not use alcohol or marijuana during this time, he did become addicted to Demerol, which he misused in an effort to alleviate his excruciating pain. Mr. Morgan believes that the pain and his permanently shortened leg were God’s ways of showing him who is in charge, and he was humbled by the entire experience. He was able to remain abstinent for approximately 7 years. “It wasn’t that I thought at that point that alcoholism itself was bad, just that [having survived the accident despite my bad behavior] “I made a decision not to mess with God right then.”

The next challenge to his sobriety came with the death of his beloved mother. She had an aneurysm that, according to the family story, developed from repeated belt beatings across her chest during her childhood delivered by her father. The aneurysm was repaired surgically, but she died unexpectedly of a blood clot on the brain, caused according to Mr. Morgan, by a medical technician’s negligence in allowing her head to strike against a piece of x-ray equipment. Overcome with grief, Mr. Morgan subsequently relapsed into alcohol and drug use.

Over the course of his active using years, Mr. Morgan relocated a number of times. He resided in several cities in Florida, Washington DC, and eventually settled in Brooklyn. There were ups and downs with brief periods of sobriety followed by long slides into drug and alcohol use, often in partnership with a new woman friend. There were fights, drug busts, arrests, criminal charges and evictions. He earned substantial money legally and illegally and lost almost all of it. During that time he never sought treatment, figuring that was for the “mentally ill.” When ordered into a treatment program by the court, he “kept getting dirty urines,” and couldn’t stay with it.

He came to the realization at the age of 60 that “drugs were not fun any longer; he felt like a fool, stupid, like a weakling and a junkie…an alkie”. He found himself homeless, living in a shelter, totally isolated from his family. He embarked slowly on a course of taking responsibility for his life, “letting go of his arrogance”. He became ready to find a new focus. Additionally, Mr. Morgan had developed a number of medical problems as a result of his lifestyle. Currently, he takes 13 different medications for high blood pressure, congestive heart
failure, diabetes, arthritis and gout. He also reports prostate and bladder problems. In addition to his physical problems, Mr. Morgan suffers from anxiety and depression. He takes Vicodin for arthritis pain and Ambien to sleep, but claims to be extremely careful about not exceeding doctor recommended use.

Mr. Morgan reported that he has been able to stay clean from alcohol and drugs for two and a half years, and is cautiously optimistic that this time his sobriety will stick. He sees a therapist now, but especially credits a few different programs with offering him the path to a new way of life. First was “Recovery Readiness,” a harm reduction program, where he felt helped by “experienced counselors with a long time in recovery.” They gave him “practical tools” to aid relapse prevention, along with important information about drugs and alcohol and about how to avoid HIV and other STD’s. At another agency, Arrive, he learned how to be a “peer advocate” and “to facilitate discussion groups with people similar to myself.” Now, at yet another agency, he volunteers with a speakers’ bureau that sends him out to speak to high school and college students about the hazards of substance abuse.

He also participates in various men’s retreats, including Bible study groups. He emphasized the reemergence of spirituality in his life. Together all these programs “have given me a purpose” in life. Mr. Morgan also says that these programs help addicts to understand their thought processes, so that they can “redirect their thoughts and interrupt any negative actions that may come to mind.”

While his “family background was spiritual” and he was raised to believe that “God is responsible for everything,” for many years he had interpreted that as a negative—that God was punishing him for his ways. Now he is starting to see God as good and protective of him. He is thankful to have survived his troubles and to wake up every morning. Finally, Mr. Morgan tries to support his sobriety program by “staying grateful, focused, not cocky, humble, and carrying the message of hope.” As for AA and NA, he feels that since “everyone shares their war stories”, 12 step meetings served as a trigger for him to start using, and therefore they “never worked”.

Aging and Substance Use

Mr. Morgan’s story is riddled with experiences that would have made many people hit physical and/or spiritual bottoms, including jail time, employment problems, medical troubles, repeated episodes of violence, and estrangement from family. While traumatizing, none of these
events seemed to discourage his drug use or induce any self-reflection on his behavior or thinking. The loss of all his material possessions and subsequent homelessness had little impact either. Rather, it was the acknowledgment of his age that really seemed to prompt him to change. The discrepancy between where he believed he should be -at his age- and where he actually found himself was quite substantial. Mr. Morgan was no longer able to maintain the lifestyle that he had so arduously held onto for nearly 40 years. His health had been damaged and the drugs were affecting his body in adverse ways. He still considers himself addicted, has the “same thoughts and temptations,” but feels he has some tools to resist, and he’s embracing “the struggle.”
Teaching Guide - Albert Morgan

The following materials have been prepared to provide you with suggestions about how to use this case in class. There are many ways you can use these materials. This guide was developed with the expectation that you would pick and choose among these suggestions based on class needs and interests.
KEY ELEMENTS AND THEMES IN THIS CASE

1. The connection between violence, trauma and addiction
2. The bio-psycho-social contributors to addiction (e.g., heredity, life circumstances, family modeling substance abuse as acceptable behavior, child abuse,)
3. The role of racism and other forms of societal oppression in substance abuse
4. The substitution of relationships with drugs/alcohol for relationships with people
5. The role of alcohol and other drugs in self-medication
6. The emergence of substance abuse in people from all walks of life, including those who are very bright and have numerous other strengths
7. The persistence of denial among people with addictions
8. The common difficulty of people with an addiction to deal with their feelings
9. The search for external solutions to personal problems, such as moving (“the geographic cure.”)
10. The willingness of some people in later life to face their addiction when they begin to look back on their lives and to realize what they have missed.
11. The older adult’s psychological task of finding ego integrity rather than despair (Erikson) and its intersection with substance abuse
12. The connection between addiction and other medical illnesses
13. The difference between early onset and late onset addiction (This is a case of early onset.)
14. The role of stigma in keeping people from seeking services
15. Recovery as a process, with intermittent relapse a part of it.
16. The importance of different service approaches and the need to find the best fit. (Some people do not find 12 step programs helpful and some find them harmful.)
17. The role of spirituality in recovery.
SUGGESTED CLASSROOM AND HOMEWORK EXERCISES

1. Have students work in small groups to identify and discuss the common themes listed above.

2. Have students discuss in small groups what surprised them about Mr. Morgan’s experiences. Did his story challenge any myths or biases they might have held about people of his age, race, or education with regard to addiction and recovery?

3. Introduce some assessment tools specifically geared to older adults, such as the Geriatric Depression Scale.

4. Have students explore national and local resources for homeless and addicted older adults and either submit a list in writing or report back to the class for discussion of both the range of existing services and service gaps.

5. Have students locate research evidence to support ongoing-treatment with Mr. Morgan. Include evidence as to what interventions are effective in preventing relapse or promoting recovery in older adults.

6. Have students look up information about the prevalence of substance abuse and co-occurring problems in older adults. Ask them to identify/consider what special risk factors for substance abuse initiation or relapse older adults face and what interventions might be most appropriate, referring to bio-psycho-social theories of addiction and recovery. This could be a final assignment.

7. Have students look up information about the prevalence of substance abuse and co-occurring problems in older adults of different racial and ethnic groups (e.g., African American, Native American, Hispanic and Asian).

8. Have students consider if or how the intervention plan might differ depending on the ethnic background of the older adult.

9. Have students pair up. Role play administering the Geriatric Depression Scale.

10. Read the following article:

DISCUSSION QUESTIONS

1. Explain the factors that may have led to Mr. Morgan’s addiction.
   - Consider the roles of heredity, family background, trauma history, relationship history, loss, racism and the role of self-medication
   - Do you agree with Mr. Morgan about the importance of his “unresolved childhood experiences” in his development of addiction? What other factors does he speak about?
   - What were the adaptive consequences for Mr. Morgan? What maintained his addiction? What did he get out of it? What intervention options are suggested by the adaptive consequences you have identified?
   - As an “early onset” drinker, how does the course of Mr. Morgan’s addiction differ from what you might typically see in someone who first became addicted as an older adult?

2. What additional information do you need from Mr. Morgan to do a biopsychosocial assessment?

3. Why after so long a period of addiction, might Mr. Morgan have entered recovery in his sixties? (Consider some life stage theories such as those of George Vaillant and Erik Erikson).

4. Mr. Morgan is currently in “the maintenance stage” of recovery (Stages of change paradigm). What elements of his life are still out of balance? What risk factors for relapse are still evident in his life? How might a social worker address these?

5. Discuss the difference between “relapse prevention” and “recovery enhancement.” What interventions might aid in each?

6. What are the strengths and limitations of the Harm Reduction approach to substance abuse?

7. What about Recovery Readiness and Arrive might explain their effectiveness for Mr. Morgan, especially in comparison to AA and NA?

8. Discuss the role of spirituality in recovery as well as self-acceptance. How do these relate to the psychological tasks of aging? How might the role of spirituality play out differently in different ethnic groups?
9. Are there gaps in the service continuum for older adults with addictions? How can an agency already providing substance abuse services expand to fill these gaps? How can an agency not yet providing substance abuse services move into this service domain?

10. How can we address the stigma attached to receiving services and how can we make it easier to access services?

11. What might have been done for Mr. Morgan as a child, teen, or young adult to prevent or halt the course of his addiction? In what role or context might a social worker have been able to intervene to help him?

12. Mr. Morgan told the interviewers that telling his story to them (and to others) “adds to his healing.” What does this suggest about the use of reminiscence interviewing in working with older adults with addictions?

13. What additional information would be helpful in understanding and helping Mr. Morgan? How would you go about getting this information?

14. How might the services an agency offers look different if serving African American, Native American, Hispanic or Asian older adults with substance abuse problems?

15. How might the older adult’s racial/ethnic background affect how the social worker works with him/her?

16. How might long-term alcohol and drug abuse have affected Mr. Morgan’s memory and judgment?

17. Would it matter if Mr. Morgan’s retelling of his story is not accurate?
Social Work Competencies For Working With Older Adults With Substance Abuse/Misuse Concerns

The following are “gerontological social work competencies” for work with substance abuse. Those in bold are addressed through this vignette.

1. Understand and direct the ways one’s own values and biases regarding aging impact professional practice and ethical work with older persons with substance abuse/misuse concerns, their families, and the provision of aging health and mental health services.

2. Integrate into the practice of social work an understanding of the life experiences and unique needs of older persons with substance abuse/misuse concerns who belong to specific racial, ethnic, socioeconomic groups; of men and women; and of those with different sexual orientations.

3. Incorporate into treatment and service planning the relationship of race, ethnicity, and culture on health status, health belief, help-seeking behaviors, health practice (i.e., traditional medicine), and health outcomes. Include knowledge of:
   a. immigration
   b. acculturation /assimilation.

4. Develop strategies to change policies and regulations to improve the well-being of older persons with substance abuse/misuse concerns and their caregivers, particularly historically underserved groups.

5. Conduct a comprehensive geriatric assessment of psychosocial factors that affect physical and mental well-being of older persons with substance abuse/misuse concerns.

6. Identify ways to ascertain the health status and physical functioning (e.g., ADLs and IADLs) of the older person with substance abuse/misuse concerns in order to provide assistance.
7. Design and implement service plans to help older persons with substance abuse/misuse concerns and their families manage/improve functioning with cognitive loss or mental health problems (e.g., depression, dementia, and delirium), health issues, and/or physical functioning.

8. Apply social work ethical principles to decisions on behalf of all older persons with substance abuse/misuse concerns with special attention to those who have limited decisional capacity including:
   a. complex situations in which self-determination and dignity are challenged or inconsistent with safety and legal concerns;
   b. reporting and intervening with elder mistreatment such as neglect and abuse; and
   c. reporting and intervening with those in danger to self or others.


10. Utilize family interventions with older persons with substance abuse/misuse concerns and their families (e.g., promote safety, restore relationships) in order to assist caregivers to reduce their stress levels, maintain their own mental and physical health and promote better care of the elder.

11. Understand the effects and interactions of multiple chronic conditions, medication, nutrition, and sudden or on-going causes of changes in cognitive states and functional capacity.

12. Develop intervention based on the stages in the late life-family and intergenerational roles and interaction.
   a. Integrate understanding of caretaker’s behavior (current and historical) that leads to engagement, withdrawal, disempowerment or empowerment of elderly relative.
   b. Support the multiple types of grandparent roles.
c. Build interventions around cultural strengths and challenges in the intergenerational family.
d. Recognize and support the diversity of family including same sex families, step-families, grandparent-headed families and other family types.

13. Assure appropriate access, utilization, continuity, coordination, and monitoring of the continuum of public resources for older persons with substance abuse/misuse concerns including community-based care, residential care, nursing home, and health/mental health services.

14. Assess and address impacts of social and health care policies on practice with historically disadvantaged populations.

15. Develop strategies to address service gaps, fragmentation, discrimination, and barriers that impact older persons with substance abuse/misuse concerns, including intergenerational approaches.

16. Adapt organizational policies, procedures, and resources to facilitate the provision of services to diverse older persons with substance abuse/misuse concerns and their family caregivers.
   a. Contribute to the development of policies covering work site inspections and safety regulations that would apply to special needs of elderly such as special provisions made for the handicapped.
   b. Advocate for the development of new roles and new options in work settings for elders, such as, specialist, consultant, part time work, and flexibility in hours.

18. Understand and be able to implement motivational strategies relevant to older persons with substance abuse/misuse concerns.


20. Be able to determine when, if and how to engage family members and significant others in provision of services to older persons with substance abuse/misuse problems.
**Background Information**

**Alcoholism.** With aging, people become more sensitive to the effects of alcohol, so that drinking, whether a new or long standing behavior, becomes more problematic in old age than it is for younger drinkers.

**Substance Abuse.** In older adults, symptoms of substance use or dependence can be difficult to distinguish from problems sometimes associated with aging, such as falls or impaired cognition.

**Prevalence:**
Approximately 2.5 million older adults have alcohol related problems. Caucasians tend to consume more alcohol, but African Americans and Hispanics tend to binge drink (SAMHSA, 1998). It is difficult to obtain accurate statistics due to the stigma attached to the problem of alcohol abuse among older adults

Approximately 1% to 2.6% of older adults reported using illicit drugs, with older black adults representing the highest percentage (Gurnack & Johnson, 2002).

Older adults are at risk for developing problems related to misuse and abuse of alcohol in combination with prescription medication and over-the-counter medication.

**Types of Alcoholism/Substance Abuse:**

**Early Onset Abusers** (2/3 of older alcoholics)
- Have usually had a lifelong pattern of drinking and most likely have been drinking alcoholically since they were young.
- Have experienced serious financial, family, career, legal and personal consequences due to their alcohol/substance abuse.
- Are more likely to require medical detoxification and hospitalization than late onset alcoholics.
- Often have a history of alcoholism/substance abuse in the family.
- Usually begin experiencing problems with alcohol/substance abuse in their twenties or thirties.
- Are more likely than late onset drinkers to have mental illness, cirrhosis and organic brain syndrome and other serious medical complications related to alcohol/substance abuse.
- Are more likely than late onset users to have abused /misused multiple substances over time (Guida et al. 2004)

**Late Onset Abusers** (1/3 of older alcoholics):
- Usually begin to experience difficulties with alcohol/substance abuse in their fifties or sixties or following retirement (Barrack & Connors, 2002).
- In general, tend to have higher incomes and be better educated than life-long drinkers.
- Often begin abusing or increase their drinking/substance abuse after a stressful life event such as a life transition like retirement, loss of a spouse, a serious medical issue or a move to a new environment.
Are more likely to engage in substance abuse following a late-in-life trauma or catastrophic event than is the case with lifelong users
- Tend to have fewer alcohol related medical problems than younger alcoholics
- As a group tend to be more receptive to treatment.

Medication misuse
- Older adults often take more prescription and over the counter drug medication than younger adults.
- Medication dosage is often related to a person’s age.
- Polypharmacy refers to the use of multiple medications. It can indicate a situation where too many medications are used.
- It may be unsafe to use over-the-counter medications and alcohol together.
- Noncompliance is often unintentional – too little or too much may be used by the older adult. Also non-compliance “takes the form of older patients’ deciding that they no longer need the medication or that it is not working for them” (Hooyman & Kiyak, 2005, p.234).
- Often older adults may misuse medication or may use medication in combination with other drugs. Older adults may not read the warning labels about their side effect and interactions with other drugs.
- Sleep medications mixed with alcohol can result in coma or death.
- Vitamins or herbal remedies may interact with prescription medication.
- Older adults may misunderstand directions for appropriate drug use—a problem that is compounded by the multiple prescriptions they may receive.
- Older adults often stockpile medication or go to a number of physicians to obtain to assure that they have a number of drugs.
- Vision changes may make it harder to read small print on medicine jars, which may lead to misuse.
- Financial concerns can affect how older people take their medications.
- “Harm reduction” services can be helpful for individuals not yet motivated to commit to abstinence. It is often more acceptable to early service users and does not preclude later commitment to abstinence. It may even accelerate an individual’s potential for continued change and can be seen as part of the continuum of services. (MacMaster, 2004)
- Motivational Interviewing can help alcohol and drug involved older adults recognize the need to change their behaviors and resolve ambivalence about seeking help. The approach is collaborative, strength based and respectful of older clients’ capacity to make responsible decisions about their lives.

Family Issues:
- Persons from alcoholic families are predisposed - or at risk to develop alcoholism.
- Social and ethnic factors interface with early family experiences surrounding alcohol use and may contribute to the way in which an individual may use alcohol throughout the life course.
Social and Psychological Issues:

- Both older adults and young adults have difficulty admitting to having an alcohol problem.
- There may be a connection between depression and alcohol/substance abuse in older adults.
- Social isolation may lead to increased levels of depression in older adults.
- Psychological consequences of alcohol abuse include increased rates of depression and suicide.
- 1/3 of alcoholics suffer from major depression (Bellenir, 2000).
- Failed relationships causing loneliness isolation from social and community supports.

Gender Issues:

- Older men are more likely than women to use alcohol and more likely than women to be problem drinkers (Holbert & Tueth, 2004).
- Women with alcohol problems tend to be more secretive about their drinking than are men.
- Differences in the development of alcohol problems may be attributed to biological factors – each ounce of alcohol consumed by women can have a more intoxicating effect than on men due to lower body weight, amounts of water, and muscle to body fat ratio.

Physical Changes in Aging that increase the vulnerability of older adults when using alcohol or other substances

- The individual may feel effects of alcohol more than when younger because the concentration of alcohol in the blood is greater (alcohol is water soluble).
- There is a misperception that alcohol is a stimulant and makes older persons feel younger and more energetic.
- Age affects the way a body reacts to prescription drugs.
- Decline in proportion of weight contributed by water
- Lean body mass in muscle tissue lost; increase in proportion of fat
- These affect the ability to metabolize many medications and alcohol
- Renal function declines, which may affect tolerance of certain medications due to less effective elimination
- Medications may remain active in the body longer
- Changes in digestion (e.g., slowing of intestinal movement) may result in decreased or delayed drug action
- Changes in liver function may mean it takes longer to break down certain drugs, which may therefore accumulate in the body
- In older people, the central nervous system is usually very sensitive to the depressant effect of alcohol
- Prescription and over-the-counter medications may intensify the effects of alcohol in older persons
- Physical changes associated with aging (e.g., vision changes, arthritis) may affect a person’s ability to take medication as prescribed.
Physical Consequences:
- All systems of the body may be adversely affected by alcohol abuse.
- Direct causal links can be made to such serious conditions such as liver disease, pancreatitis, and hypertension.
- There may be more indirect medical complications which are more difficult to link to an older adult alcohol/substance abusers such as hypertension, heart disease, peptic and duodenal ulcers, gastritis, impaired immune system, malnutrition, broken bones, sprains bruises and multiple contusions.
- Cognitive complications may include; short-term memory loss, and impaired judgment. These symptoms can often be misinterpreted by healthcare professionals as complications arising from the normal aging process rather than from alcohol/substance abuse.
- Unsteady gait and frequent falls.
- Older adults taking medications are at increased risk of falling.

Risk Factors:
- Previous history of alcohol or drug abuse
- Untreated psychiatric problems, especially anxiety and depression
- Chronic pain or other limiting conditions
- Limited family and social supports
- Bereavement and loss of other important relationships
- Having more than one prescribing physician
- Combining mood altering drugs with alcohol
- Family history of alcohol/substance abuse

Possible Signs and Symptoms of Alcohol/Substance Abuse in Older Adults:
- Changes in sleep patterns
- Recurrent episodes of confusion
- Unsteady gait- frequent falls, trips to the emergency room
- Lack of energy, fatigue
- Slowed thought processes
- Changes in vision
- Boredom or loss of interest in activities
- Changes in hearing
- Progressive memory loss
- Isolation
- Long term use of mood altering drugs
- Depressed or anxious mood
- Signs of alcohol problems in older persons are often mistaken for signs of aging or chronic illness

Screening
- Accurate identification of drinking and substance abuse is critical. It is not easier to detect an alcohol problem in an older person than it is in a younger adult.
- Screening instruments can be valuable to help recognize individuals at risk or who are abusing alcohol and substances.
• The CAGE 4-item questionnaire is a commonly used screening tool for alcohol abuse, but its use with older adults is mixed.
• The Michigan Alcohol Screening Instrument – Geriatric Version (MAST - G) and its shorter version (S-MAST) are better tools to screen for alcohol abuse and their reliability and validity to use with older adults have been documented.
• The Alcohol-Use Drug Identification Test (AUDIT) is also well accepted in the field.

Interventions with Older Adults around Alcohol/Substance Abuse

• A person does not have to want to stop drinking before he or she can be helped to stop
• Fleming and colleagues (1999) noted a brief intervention program, which included providing physician advice about reducing alcohol use, at 3, 6, and 12 months. Older adults who received the intervention had a 34% reduction in 7-day use, 74% reduction in binge-drinking, and 62% reduction in the percentage of older adults drinking more than 21 drinks per week compared with those who did not receive the intervention. (Fleming, Manwell, Barry, Adams, & Stauffacher, 1999).
• Blow and colleagues also “suggest” from early findings that brief motivation intervention can make a difference in substance use of older adults with hazardous drinking. Preliminary results found that older adults who received the brief intervention reduced their frequency and use of alcohol compared with the intervention group.
• In a study of hazardous drinking older adults, interventions including motivational enhancements, brief advice, and standard care were compared. After 1 year, older adults in both the intervention groups and even standard care found a decrease the drinks and number of days abstained (Gordon et al., 2003)
• Copeland (2003) also found that brief intervention can make a difference in health behavior change. They did not study use, but found that a brief intervention program can make a difference in health behaviors, such as seeking care and help.
• Lowe and colleagues (2000) found that home visits with older adults to help explain the purpose and use of medication increased compliance. The home visit teaching sessions clarified use, side effects, and interaction problems for older adults.
• Integrative Reminiscence (Watt & Wong, 1991) may be of value to older adults in recovery seeking meaning in their lives and reconciliation with their past years in substance abuse.
• Specialized groups for older adults within a structured therapeutic residential community were found to offer an effective treatment intervention for older adults with substance abuse disorders. (Guida et al., 2004)
• For life long users, groups offering relapse prevention strategies and realistic practical techniques for daily living are most helpful (Guida et al, 2004)
• For late onset users, abandonment and loss are primary issues. Psychological support in groups and aftercare role modeling promote recovery (Guida et al, 2004).

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<td>Resource</td>
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<td>CAGE Questionnaire – Screen for Alcohol Misuse</td>
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<tr>
<td>Prevention of Medication Misuse in Older Adults</td>
<td>Older Americans Substance Abuse &amp; Mental Health Technical Assistance Center. (n.d.). <em>Prevention of medication misuse in older adults</em>. Downloaded from <a href="http://www.samhsa.gov/OlderAdultsTAC/docs/Medication_Booklet.pdf">http://www.samhsa.gov/OlderAdultsTAC/docs/Medication_Booklet.pdf</a></td>
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<td>Prevention of Alcohol Misuse for Older Adults</td>
<td>Older Americans Substance Abuse &amp; Mental Health Technical Assistance Center. (n.d.). <em>Prevention of alcohol misuse in older adults</em>. Downloaded from <a href="http://www.samhsa.gov/OlderAdultsTAC/docs/Alcohol_Booklet.pdf">http://www.samhsa.gov/OlderAdultsTAC/docs/Alcohol_Booklet.pdf</a></td>
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