Teaching Workbook for

Social Policy Analysis, Advocacy and Practice: Substance Abuse

Susan Olin’s Story

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Vignette – Susan Olin

The following vignette is based on an oral history of substance abuse taken in a single interview with an older adult willing to share her 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 her relationship with drugs. Only her name and identifying details have been changed.

Description

The interview with Ms. Olin took place at a senior center in New York City. Susan Olin is a 58 year old Caucasian, single woman who has lived in New York all of her life. She was neatly dressed and soft spoken but appeared drawn and older than her stated age. Ms. Olin appeared slightly anxious and frequently clasped and unclasped her hands throughout the interview. She explained that she was willing to be interviewed in order to help other older persons experiencing problems with substance abuse.

Ms. Olin currently lives illegally in an apartment in public housing on the same grounds as the senior center where the interview took place. She is not named on the lease but sleeps on a couch in the living room of a “friend,” a man she knew tangentially in the drug world who is the official tenant. She pays him a modest rent but can only stay in the apartment when he is there, as he will not give her a key. As a result she spends a lot of time on the streets. When she is in the apartment, life is also difficult because she is trying to recover from a serious drug addiction and her friend is currently abusing heroin and alcohol, sometimes smoking crack and “blowing it in her face.” There was an underlying tone of hopelessness when she talked about her living situation because of the fact that it is her friend’s apartment and she has no financial resources of her own that would enable her to find another place to live.

Family Background

Ms. Olin describes a painful, intergenerational family history of substance abuse. She is the sole survivor of three siblings. Her father passed away many years ago. Her mother is still living but “wont’ talk to her.” Both parents, she implied, had also “had problems” with alcohol and substance abuse. Ms. Olin then talked about having had two children of her own and her voice seemed to become even softer at this point in the
interview. “I had one daughter who died of an overdose of drugs four years ago at the age of 21.” She then went on to say that she herself began abusing drugs at the age of 21 and that this is when she began to have serious problems. In a monotone, emotionless voice she talked about the fact that her other adult daughter is doing very well, “has a wonderful job” right in the city but that they have not spoken in a very long time. “My oldest daughter disowned me years ago,” she said. Nevertheless, Ms. Olin said that the fact that her daughter has cut her out of her life is something that she does not dwell on or think about very often because she does not want to become emotionally upset.

Substance Abuse History

When Ms. Olin first began to use and abuse drugs, her drugs of choice were cocaine and heroin. Her use of drugs escalated very rapidly and began early on to interfere with her ability to function in the world. Ms. Olin attempted to stop abusing drugs but instead switched substances to the anti-anxiety drug Valium and the opiate painkiller Vicodin. This attempt to control her illicit drug use by using legal drugs failed. During this period her brother and sister (who also abused drugs) died, apparently from drug overdoses. While on the one hand this frightened her and made her want to get off drugs, it also led to deep grief which plunged her further into drug abuse. The year she was 22, for example, she was hospitalized twelve times for detoxification but each time she was released she began immediately to abuse drugs again. By then her substance use included cocaine and heroin as well as anti-anxiety drugs and painkillers. In the years that followed Ms. Olin was in and out of many detoxification and drug treatment programs with little success at staying drug free. Ms. Olin developed Hepatitis B at one point but did receive successful treatment for the illness. She also contracted Hepatitis C which is currently one of her several serious medical problems.

By her early 40’s she was homeless and has been essentially homeless ever since. She believes that this is a direct consequence of her drug addiction. She states “In the past year I finally got sick and tired of feeling sick and tired”. “I realized that I was getting too old to continue on the way I was going”. She applied to a hospital based detox program but was rejected because they said that her blood and urine showed no traces of narcotics, though she said she had used 12-15 hours earlier. She was finally accepted at
a methadone outpatient program at a major medical center in New York City. Ms. Olins’s eyes brightened and her voice grew stronger as she talked about the help she is receiving at this hospital, which includes psychotherapy and case management as well as medical and drug treatment. “They have really helped me there...They are helping me to live drug free and are also helping me with my present everyday living problems.” She speaks hopefully of getting off methadone, too, at some point, but has no concrete plans to attempt this. She is receiving Social Security Disability (SSI) payments of $700 a month, and describes her finances as “very tight.”

Two years ago she received one of the much-sought-after Section 8 vouchers, and recognized that she was lucky to get it. Caseworkers at the hospital and the senior center tried through several realtors to find her an apartment that would accept the vouchers. However, she missed several appointments to see apartments. The voucher expired and cannot be renewed. If she were to apply for her own apartment in public housing, the waiting lists would be very long and her history of arrests for shoplifting might prejudice her application. Her caseworker at the senior center would like to see her enter one of the transitional housing programs with supportive services for people with mental illness or substance abuse problems, but these programs only take admissions from city shelters. She spent some time in a shelter 12 years ago and says it was a “horrible, horrible experience.” She refuses to return even to advance her access to supported housing.

Ms. Olin feels grateful that she can come to the senior center every day, because it helps her to “stay straight” and she feels good about helping some of the older persons at the center. She is also appreciates having lunch and sometimes breakfast there. She describes the environment in the housing project where she now lives as “drug infested” and not healthy for someone recovering from addiction issues. She attends 12-step meetings to support her recovery process. She goes to both Alcoholics Anonymous (AA) meetings and Narcotics Anonymous (NA) meetings, partly as “a place to go,” when she is unable to be in the apartment. (AA meetings are more plentiful and they tend to have a stronger foundation than NA meetings in the 12 step model. Many narcotics addicts attend both.) She finds both very helpful and says she does not presently have a sponsor but is looking for the right person to be able to sponsor her. Ms. Olin describes herself as “being in recovery” and says she has not abused drugs for almost a year but when
questioned further she discussed a painful lower back condition for which she is taking about nine to twelve pain pills (Oxycontin) a day prescribed by her physician. She seems to believe that because they were prescribed for her by a medical doctor for a “real” physical condition that it does not compromise her recovery in any way.

**Aging and Substance Abuse**

Ms. Olin was very open about the fact that she no longer feels she has the energy to “cop drugs” and live on the streets. Also, the access and connections she had to the drug world have diminished as she has aged. Physically she is aware that her body has aged and does not deal well with the abuse of drugs in the way it was able to when she was younger. She describes feeling worn out, tired and sad about not having her own living space at this stage of her life. Ms. Olin expresses hope about her future and thinks that she will receive the help she needs from the caseworker at the methadone program to find an apartment along with support to “stay off drugs”. She is very glad that she finally has been successful in maintaining what she describes as “sobriety and recovery”.

Ms. Olin talked initially in a somewhat detached manner about the many losses she has experienced over the years. However, when she began to speak about the loss of the relationship with her daughter, her eyes filled with tears. “My daughter blames me for her sister’s death, she said.” She quickly dried her eyes and went on to change the subject and to talk about “letting bygones be bygones”

At the end of the interview Ms. Olin expressed how happy she felt that her interview might help someone else.
Teaching Guide—Susan Olin

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.
Teaching Guide—Susan Olin

KEY ELEMENTS AND THEMES IN THIS CASE

1. The intersection between poverty, homelessness, aging and substance abuse

2. Fragmentation of services—leading to persons with substance abuse problems falling between the cracks. E.g., Ms. Olin lost out on housing for failure to keep appointments. Why didn’t she keep her appointments? Would intensive case management or another bridging service have enabled her to keep her appointments or encouraged the housing system to accommodate more to her needs and problems?

3. Housing policies that may serve as a barrier to those who may need the housing most—including people with substance abuse problems or minor criminal history.

4. The priority given to shelter residents for supported housing to the detriment of those coming from equally impermanent community settings.

5. Policies that would allow job training/ opportunities for older adults, especially those with histories of substance abuse


7. The shortage of services for older abusers of substances—“age friendly” substance abuse services where older adults will feel welcome and where staff understands their needs and concerns.

8. The need for service provider training in the physical and medical aspects of substance abuse in older adults, including changes in physiologic response to drugs and alcohol, and risks posed by their interactions with prescribed drugs.

9. The funds, availability and effectiveness of early intervention programs.

10. Policies governing the length of time one can stay in detox and policies governing the role of social workers connecting people leaving detox with post treatment follow-up. (These might be hospital policies, state policies or insurance company policies.)

11. The need for policy to support a range of treatment approaches to substance abuse in older adults as “one size treatment” may not fit all.
1. A Geriatric Chemical Dependence Act was introduced in the New York State Legislature in 2006 to make grants available to providers to develop and implement innovative service approaches to serve older New Yorkers with chemical dependence problems. Programs could include education, prevention, treatment, workforce development and training all focused on specialized service to older adults. This bill was passed by both houses of the legislature in two successive sessions and was vetoed by two successive governors on the grounds that the Office of Alcohol and Substance Abuse Services (OASAS) was authorized to carry out such programs and therefore a separate statute and separate funding stream was not needed. Advocates were later able to have their proposals included in amendments to the Geriatric Mental Health Act, which appear to have a better chance of passing. (See Addendum.)

- Have students research the evidence base for specialized geriatric services. What is the nature of the evidence and how strong is it? Consider the type of evidence (such as controlled clinical trials, case studies, etc.) and for whom the evidence is most relevant (e.g., men or women, old or young, particular racial or ethnic groups).
- Have students debate the pros and cons of maintaining substance abuse services for all ages under centralized regulation and funding from OASAS vs. providing specialized services for older adults with separate funding and separate government oversight.
- Have students read the Chemical Dependence Act, the sponsors memo and the governor’s veto message (available at http://public.leginfo.state.ny.us/bstfrmef.cgi, Assembly bill 1453-A). Analyze the act according to the model of analysis used in your course (Jansson, Gilbert & Terell, Chambers, Chapin, etc.) This could be a written assignment or a group in-class discussion exercise.

2. An internet assignment: Have students identify policy advocacy organizations in alcoholism and substance abuse, and determine how many, if any, have taken a position on the needs of older adults with alcohol or substance abuse problems. Ask them to comment on the possible reasons for any discrepancy they find between attention to younger and older substance abusers.

3. Have students prepare a 5 minute oral testimony to a mock legislative hearing in support of the Geriatric Chemical Dependence Act, (or simply in support of more funding for geriatric alcohol and substance abuse services.). While the class plays the role of legislative committee members, presenting students could play such roles as social worker, consumer, family member, etc. and be asked to distribute brief written summaries of their testimony to the class. Someone might play the part of Susan Olin or another older person with an alcohol or substance abuse problem. Data about prevalence of the problem, the need, successful programs, as well as personal stories should be presented.
4. A public hearing was held for the Geriatric Chemical Dependence Act, before the legislators voted. Witnesses were asked to direct their testimony to particular questions (available at http://assembly.state.ny.us/Aging/20070813/). Students could be asked to prepare testimony in answer to one or two of these questions, using social science literature, position papers of advocates and consultation with practitioners in the field.

5. This could be adapted as a written assignment in which students would have to search the literature to substantiate the needs and to locate evidence (including legislation from other states and localities) that supports their recommendations.

6. Have students investigate what coverage Medicare provides for substance abuse services.

7. Create an eco-map for Susan Olin that includes policies or programs affecting her.

8. Members of this family could have benefited from prevention services, particularly those targeted to youth with a family history of substance abuse who are particularly vulnerable to abuse themselves. Students could be asked to research the evidence for effectiveness of prevention programs for youth, and make some inferences as to the human and financial cost savings over the last 40 years to Ms. Olin and to the tax paying public if Ms. Olin had received prevention services as a teenager.

9. In tight-money times, substance abuse services are vulnerable to cuts. Have the class develop an advocacy agenda to counteract proposed cuts to substance abuse services, especially services for older adults.

10. Read the following article:


   To what degree can you apply the therapeutic jurisprudence perspective to the case of Susan Olin?

**DISCUSSION QUESTIONS**

1. If separate substance abuse services are made available to older adults, with specialized funding, how should eligibility be determined? Services under the Older Americans Act are for those over 60. Medicare covers medical treatment for people over 65. Susan Olin is 58 years old. Should she be eligible for a geriatric substance abuse program? Why or why not?
2. Name three local, state or federal policies that are relevant to Ms. Olin’s situation. In what way do these policies facilitate or create barriers to her achievement of optimal functioning?

3. How have city, state or federal housing policies worked for or against Ms. Olin?

4. Why might the housing authority give priority for supported housing to applicants from shelters over applicants from marginal housing situations such as Ms. Olin’s? Given the shortage of supported housing, is this policy a reasonable or equitable one? What changes would you suggest?

5. Consider the rigid guidelines pertaining to the use and expiration of Section 8 vouchers. How realistic are they for persons with multiple problems? Why are they not more “user friendly”? What would happen if they were? If the vouchers were extended repeatedly to substance abusing applicants who miss appointments, would this be fair to others on the waiting list?

6. Should arrest records or even criminal convictions prejudice an application for public housing? Consider this from the perspective of the residents already living in the housing as well as from the perspective of the substance abusing applicant with a “record”. Does using arrests and convictions constitute a form of institutional racism? Does ignoring them suggest institutional racism? Are all arrests and convictions the same? Should one look at the nature of the crime, when it occurred, etc.?

7. What changes in housing policy might help Ms. Olin? Do you believe these changes would affect her substance abuse and potential for sustaining her recovery? Why or why not?

8. Are there policies that govern senior centers and services that have a real or potential impact on Ms. Olin? What is the role of senior centers with regard to substance abusing participants? How are they funded? Could the centers provide some substance abuse services? Should they? If not, how can they be helpful to people with substance abuse problems?

9. How have drug policies determining services and access affected the course of Ms. Olin’s drug abuse and recovery? Would the answer to this question be different for people of different ethnicities or people at different income levels?

10. Can individuals like Ms. Olin live solely on SSI ($700.) a month? What other income or in-kind services are available to assist her? Which ones is she accessing? Which ones might she access?

11. Ms. Olin has qualified for SSI based on her medical problems. However, since 1996, people with a primary diagnosis of substance abuse or alcoholism have been denied social security disability benefits either under SSDI or SSI. What
values and assumptions on the part of policy makers might have prompted this policy change?

12. Later, an exemption to the SSI disentitlement was made for people with a dual diagnosis of mental illness and chemical addiction (MICA). What might have prompted this partial restoration? (In fact, lobbying by the National Alliance on Mental Illness—NAMI.org--- created pressure to restore SSI for persons with a dual diagnosis. NAMI, founded in 1979 has affiliates in every state and more than 1100 localities.) This could lead to a discussion of how well coordinated advocacy can preserve programs or benefits for client sub-groups, even when benefits for the larger group are threatened. A debate/discussion could be held about the ethics of doing advocacy for a sub-group rather than an entire population affected by a policy.

13. What advocacy groups and/or other organizations might you partner with in a campaign for the development or passage of legislation to assist older adults with alcohol or substance abuse problems?

14. What are the advantages and disadvantages of integrating mental health and substance abuse services for older adults? What would policies to achieve this end look like?

15. Consider the history of the New York State Geriatric Chemical Dependence Act and its ultimate merger into the Geriatric Mental Health Act. (See Addendum.) Why might chemical dependence advocates prefer their own bill? What are the pros and cons of having chemical dependence added to the purview of the Geriatric Mental Health Act? If you were advising advocates for geriatric substance abuse programs, which path would advise them to follow? Which approach makes better public policy and why?

Considering the fate of the final bill that was passed (with an expanded advisory council but no new money) have substance abuse advocates gained ground, lost ground or stood still?

What should the role of advocates seeking funding for their cause be in tight money times?

16. From an advocate’s perspective, what are the pros and cons of working for incremental vs. major policy changes?

17. When resources are scarce, substance abuse programs along with other social programs are vulnerable to cuts. How are priorities determined when competing interest groups have different agendas (e.g., health care, education, lower taxes)? To what extent are choices rational (based on evidence and logic), political (based on the relative power of competing groups) and/or expedient (based on feasibility)?
18. Methadone maintenance is essentially a harm reduction program. It seems that Ms. Olin has been able to access detox programs and now a methadone maintenance program; however, she has apparently not succeeded at or not been referred to drug treatment programs with a goal of total abstinence. How have our drug policies that determine services and access to them affected Ms. Olin’s course of drug abuse? Should Ms. Olin have been referred to a drug free program rather than a methadone maintenance program? Since she is in a methadone program, should efforts be made to withdraw her from methadone eventually? What is the evidence on the long-term consequences of methadone maintenance for older adults?

19. What is the research evidence supporting the use of harm reduction strategies such as methadone maintenance vs. that supporting drug free approaches? Do we value one more than the other? Should policy and related budget decisions favor one over the other? For everyone? For older adults in particular?

20. How should drug maintenance such as methadone for the disease of drug addiction be viewed in comparison to drug maintenance for other chronic diseases, e.g., insulin for diabetes or psychotropic drugs for chronic persistent mental illness? Should the goal always be to wean people off drugs in such circumstances? Is methadone maintenance different? If so, how?

21. In your opinion, does age, gender, race or ethnicity affect decisions about whether substance users are referred to programs aiming for abstinence or to those focused on harm reduction? Can you find evidence in the literature to refute or substantiate your view? (Part two could be a homework assignment.)

22. How much of Ms Olin’s repeated cycling through detox and treatment without success was because she wasn’t ready and how much was related to the systems designed to help her? Ms. Olin’s repeated cycling through detox and treatment without success suggests a mismatch between what was offered and what she wanted or needed. What services or package of services might have helped her better manage her addiction? When she began seeking treatment in her early 20’s was she offered housing assistance, job training, or ongoing support? If not, what policies or lack of policies prevented this? When, in her forties, she was admitted to a methadone program that provided ongoing psychotherapy and case management, she finally stopped using drugs. Would her current situation be better if she had been offered these services when she first sought treatment?
Addendum: The Geriatric Chemical Dependence Act—
A tale of advocacy and compromise in New York State

The small number of practitioners in chemical dependence of older adults had long felt that older chemically dependent adults were given short shrift in funding and attention by the larger substance abuse treatment community, resulting in a shortage of specialized services needed by this population. Project 2015, a statewide initiative launched in 2000 to gather input into planning for the future aging population in New York, had identified substance abuse among seniors as growing concern. Statewide forums and reports echoing this concern followed, but no official actions were taken.

In 2006, advocates were successful in having a bill introduced in the New York State legislature that would provide grants for innovative prevention and treatment programs, education and outreach to seniors, and training of service providers, all focused on specialized services to older adults. Titled the Geriatric Chemical Dependence Act, it would be administered by the state Office of Alcoholism and Substance Abuse Services (OASAS) with the cooperation of the State Office for the Aging (SOFA). It would also provide for an interagency planning council to monitor service needs and make recommendations annually to the commissioners of OASAS and SOFA. The bill passed overwhelmingly in both houses of the legislature in two successive sessions but was vetoed by two successive governors on the grounds that OASAS was aware of the need and was authorized to establish programs for seniors, so that a separate act was not needed.

Advocates regrouped and joined forces with the Geriatric Mental Health Community. In January, 2008, a bill was introduced in the legislature to broaden the Geriatric Mental Health Act, which had been passed in 2005, to include chemical dependence programs in its grants, and to lodge those programs in the Office of Mental Health. An interagency planning council already in operation would be expanded to include representatives from OASAS. This bill passed both houses of the legislature in quick order, and the Governor’s approval was expected. However, because of a sharp unanticipated downturn in the state’s economy, the Governor vetoed this bill. He signed an alternate bill that provides for the expanded Interagency Council, but does not provide money for new demonstration grants. So, the geriatric substance abuse community has won a seat at the table, but for the present no additional funding.

Initially, advocates from the chemical dependence community feared that their interests would be overwhelmed by those of the larger geriatric mental health community, much as they had earlier feared being lost in the interests of the larger substance abuse community. However, they realized that they could achieve their aims faster by attaching their proposed grant program to the already operational Geriatric Mental Health Act. They were also aware that the current Governor’s administration favors plans that integrate services over plans that establish new “silos.”

Both chemical dependency advocates and mental health advocates were wary that an integrated program might result in a limited pot of funds being spread further with loss to
both sides, but they were able to win assurances from the chairpersons of the Assembly Committees on Aging and Mental Health that legislators will support additional funding over that originally allocated to the mental health act. That commitment is still in place, but in light of the state’s fiscal crisis, that new funding will not be forthcoming in the near term.
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, regulations, and programs 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 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).

**References**


### Resource Materials

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<th>Resource</th>
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<td>Medication Misuse Among Older Adults</td>
<td>Ohio State University Extension. (2001). Medication Misuse Among Older Adults (Senior Series Publication SS-128-07-R02). Downloaded from <a href="http://ohioline.osu.edu/ss-fact/0128.html">http://ohioline.osu.edu/ss-fact/0128.html</a></td>
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