



Working with Aging Client Populations:

Preventing, Identifying and Treating Alcohol & Substance Abuse and Supporting Recovery

*New York State Office of Alcoholism & Substance Abuse Services
Addiction Medicine Unit
Senior Services Initiative*

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 - New York State Office of Alcoholism and Substance Abuse Services
 - Cicatelli Associates, Inc.
 - Empire State Training Association
- **“Substance Abuse Among Older Adults”: Treatment Improvement Protocol #26**
 - Substance Abuse and Mental Health Services Administration
 - Center for Substance Abuse Treatment, Rockville, MD



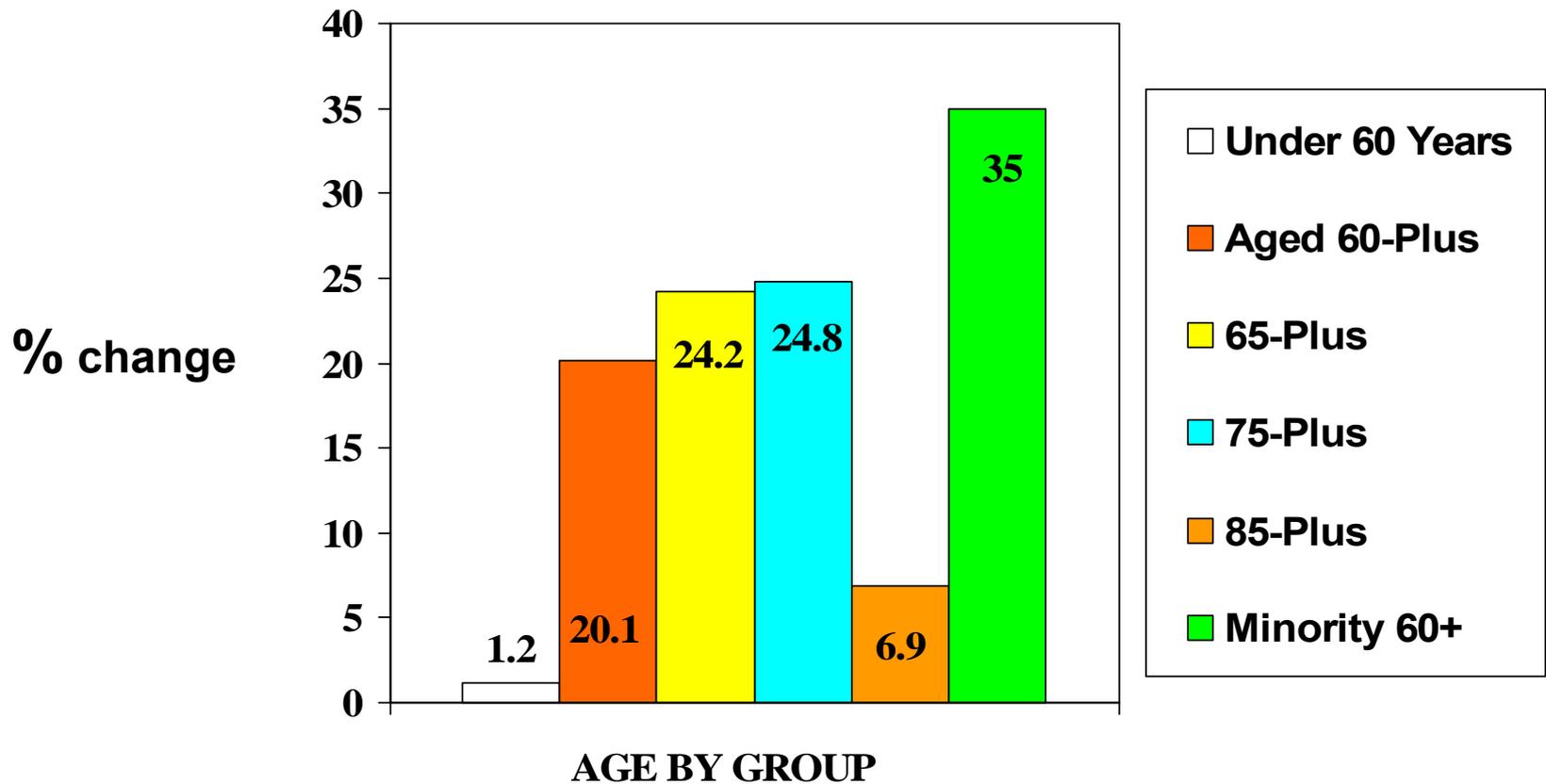
The training was developed in collaboration with the New York State Office for the Aging (NYSOFA)



OASAS & New York's Seniors



2001 to 2015 Projected Rate of Growth Selected Age Groups



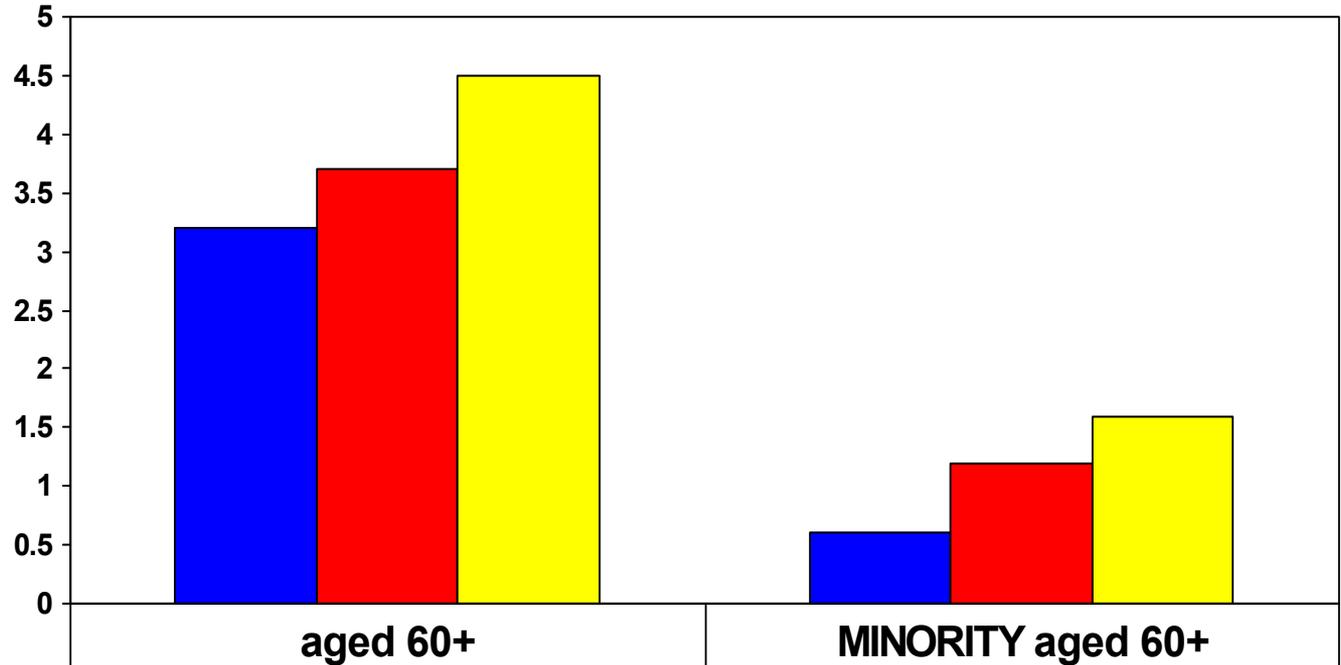
Source: NYS Office for the Aging



1995 - 2025 New York State Population

Aged 60+ and Minority Aged 60+

Growth
[in Millions]



■ 1995	3.2	0.6
■ 2015	3.7	1.2
■ 2025	4.5	1.6



Prevalence

Geriatric Alcohol & Other Drug Problems

- General population..... 2 - 10%
- Medical inpatients..... 18%
- Psychiatric inpatients... 37- 44%
- Nursing home patients.. Up to 20%



Prevalence:

Alcohol and Drug "Problems" Among Seniors

OASAS [New York State] applies the
prevalence estimate cited by US Dept. of Health & Human Services / Substance Abuse and Mental Health
Services Administration (SAMHSA) =

17%

**Prevalence of Diagnosed / Undiagnosed / Misdiagnosed Incidence in
General Population**

US Department of Health and Human Services [HHS]

Substance Abuse & Mental Health Administration [SAMHSA]

Center for Substance Abuse Treatment [CSAT]

Center for Substance Abuse Prevention [CSAP]



Consider the risks & consequences of an older adult's use of :

- Alcohol
- Over-the-counter drugs
- Illegal drugs
- Combined use of any of the above at the same time



What are “OASAS Services”?

- Education - Training
- Prevention
- Intervention - Referral
- Treatment
- Community-based support linkages



OASAS Certified Service Categories:

1. Prevention
2. Crisis Services
3. Outpatient
4. Inpatient
5. Residential
6. Methadone Services



Prevention:

- education, counseling
- community, group, individual



Crisis services:

- Persons who are intoxicated or incapacitated by their use of alcohol and/or substances
- Management and treatment of withdrawal
- Medically managed detoxification
- Inpatient/residential medically supervised withdrawal services
- Outpatient medically supervised withdrawal services
- Medically monitored withdrawal



Outpatient:

- Short & Long Term
- Less or More Intensive
- Multi-disciplinary clinical services or persons with alcohol or substance abuse problems
- Family members or significant others whose functioning is impaired by another person's use of substances
- Services for individuals who live at home or in other residential settings
- Specific outpatient -- or "ambulatory" -- services can range from alcoholism treatment and "drug-free" substance abuse treatment to methadone maintenance for individuals addicted to heroin



Inpatient:

- Safe and efficient setting to provide intensive evaluation, treatment and rehabilitation services which consist of medically-supervised, 24-hour a day, 7 days per week care
- Intensive management of chemical dependence symptoms; medical management and/or monitoring of physical or mental complications
 - 13 OASAS-operated Addiction Treatment Centers (ATCs) located throughout New York State.



Residential:

- For persons who are unable to maintain abstinence or participate in treatment without the structure of a 24-hour residential setting.
 - Assistance in developing or maintaining recovery through a structured alcohol- and drug-free setting
 - Encouragement of peer group support
 - Assistance in the skills of independent living
 - Intensive enhanced medical and psychiatric management pairs an intensive residential service with a NYS Department of Health licensed Article 28 Diagnostic and Treatment Center. This allows for the delivery of services to individuals who have additional physical or mental health problems
 - Residential rehabilitation provides services appropriate to individuals suffering from substantial deficits in personal, social and vocational skills
 - Community residential services provides transitional environment for individuals who have completed a course of treatment, but who are not yet ready for independent living due to unresolved clinical issues, or unmet needs for personal, social or vocational skills development
 - Supportive living provides a long-term supportive environment following care in another type of residential service

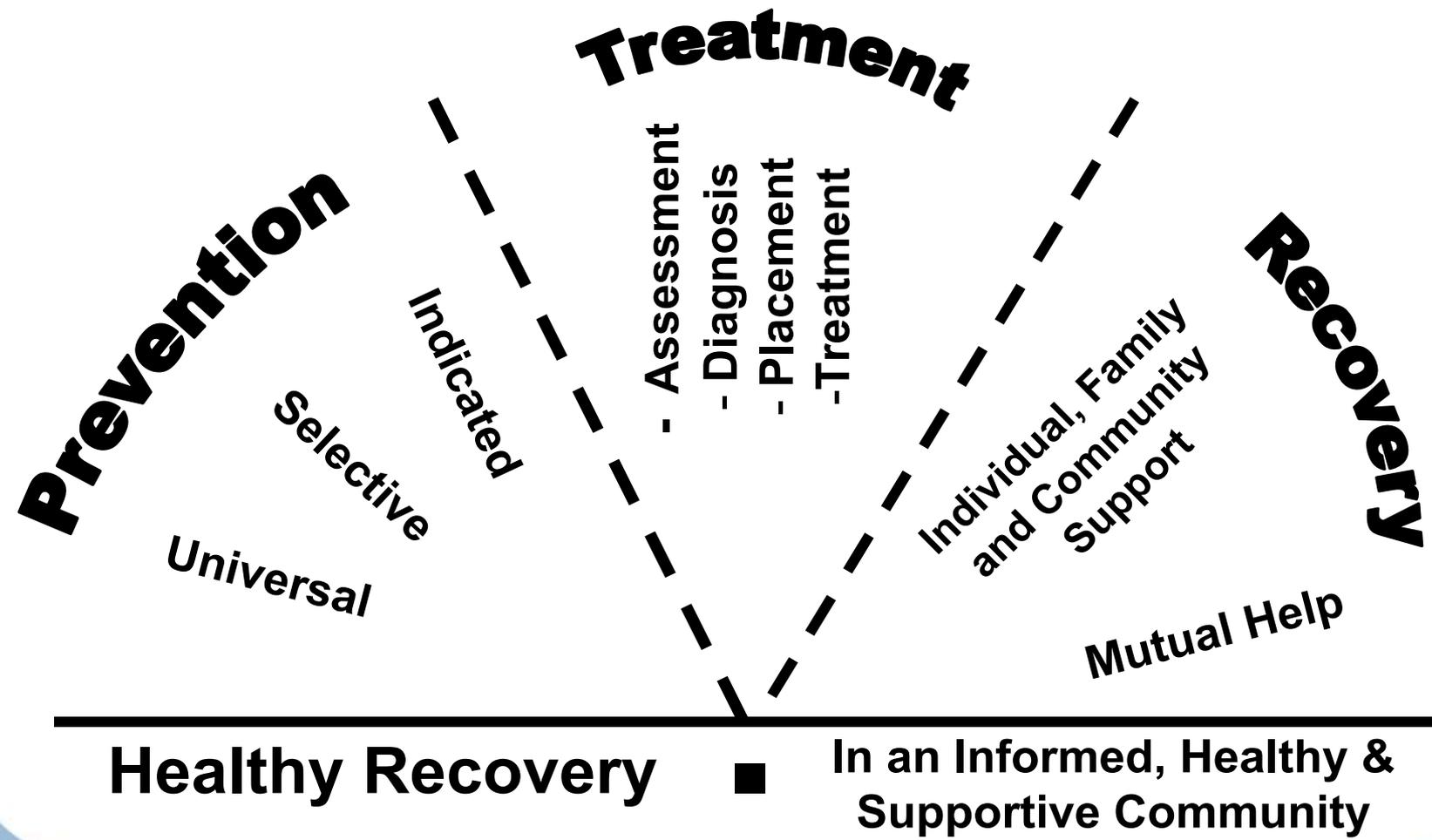


Methadone Services:

- Health care and medically prescribed methadone
- Comprehensive social and rehabilitation services
- Services to persons dependent on opiates, such as heroin and morphine so that they may develop productive lifestyles. These programs offer methadone as part of a range of medical procedures and services. Included in these services are supportive counseling, medical care and other individualized services
 - Maintenance Outpatient - The vast majority of persons receiving methadone treatment are on an ambulatory maintenance protocol. These programs are generally affiliated with a hospital or are free-standing entities
 - Residential provides methadone treatment in a residential setting on a short-term (1-3 months) or long-term (6 months) basis
 - Methadone-To-Abstinence is a medical treatment protocol that utilizes methadone in gradually decreasing doses to the point of abstinence, followed by aftercare treatment

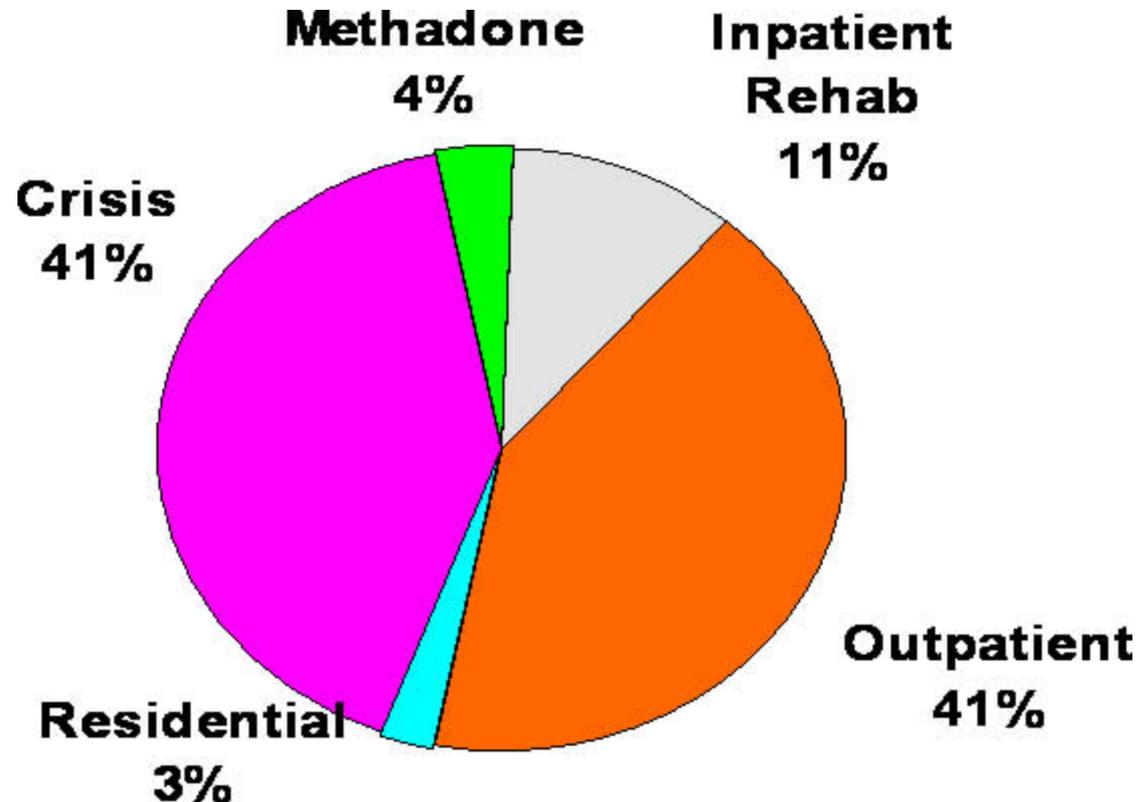


OASAS Continuum of Prevention and Treatment Services



OASAS Treatment Services Used by Seniors [55 years +]

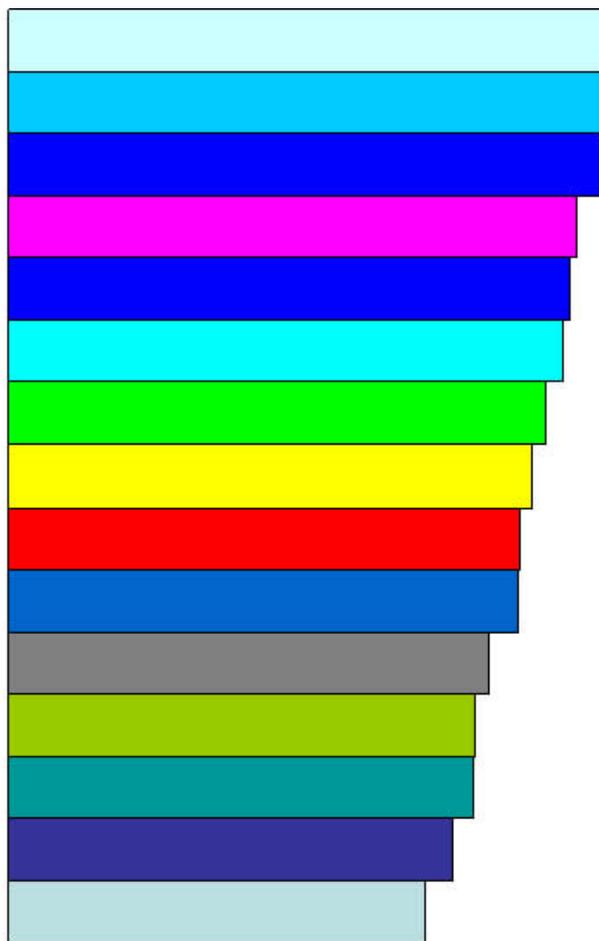
Year: 2003



Accessibility to Seniors: Community Linkage Services

Survey response from 589 OASAS-licensed service providers on a scale of
 "1 = Least Accessible" to "5 = Most Accessible"

- Emergency**
- Hospital**
- 12 Step**
- Pharmacy**
- Mental Health**
- Primary Health**
- Educational**
- Vocational**
- Visiting Nurses**
- Peer Support**
- Adult Protective**
- Transportation**
- Legal**
- Housing**
- Homeless**

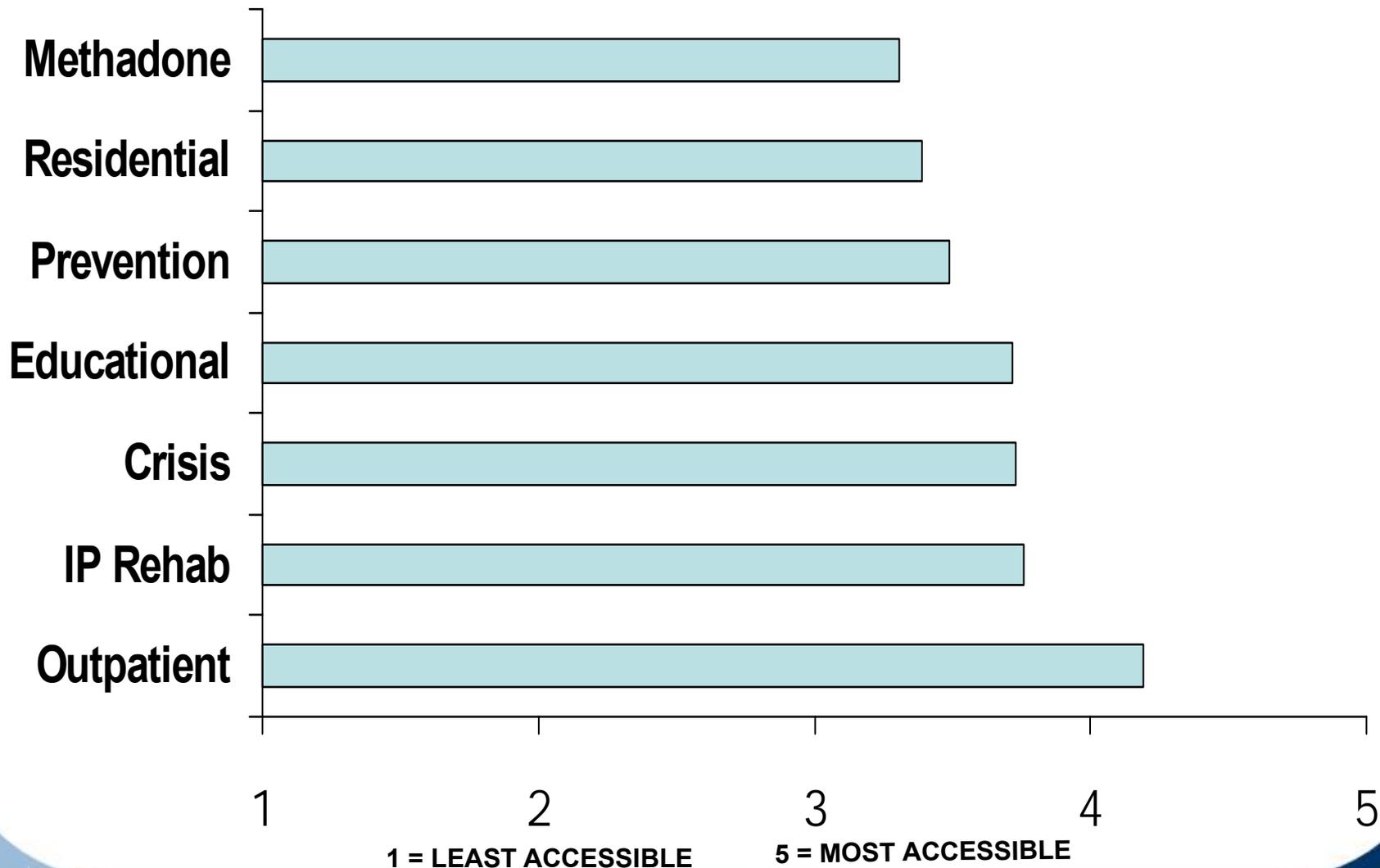


5 = Most accessible

1 = Least accessible



Survey of OASAS Providers:
LOCAL AVAILABILITY to Seniors of Alcohol & Drug Services



Recommendation:

- Some seniors might be:
 - Incapacitated
 - Disconnected
 - Frail
 - Undiagnosed
 - Disabled
 - Misdiagnosed
 - Isolated
 - Hiding
- Link substance abuse services for seniors to:
 - Health Care
 - Senior Services
 - Pharmacists
 - Housing Agencies / Management
 - Other “Community Gateways”



Consider these and other GATEWAYS where seniors are met:

- Hospitals
- Mental Health Programs
- Emergency Rooms
- Health Care Providers
- Doctors' Offices
- Home Health Care Agencies
- County Office for the Aging
- Lawyers
- Workplace - EAP
- Families
- Synagogues
- Churches
- Temples
- Mosques
- Faith-based volunteers
- Clergy
- Hospice
- Private Homes
- Prisons and Jails
- Police Stations and Courts
- Probation and Parole Offices
- DWI Programs
- Schools
- HIV/AIDS Services
- Social Services
- Senior Centers
- Veterans Services
- Methadone Programs
- Emergency services
- Visiting Nurses
- Nursing Homes
- Adult Protective Services
- Drug Stores
- Housing Authorities
- Shelters



Consider the Individual

- Daily Activities
- Vitality – Stamina
- Mental Health
- Aspirations
- Care giving – responsibilities and/or needs
- Medical history, status, needs and prognosis
- Family and social ties
- Finances
- Safety and fears
- Gender - Sexuality
- Ethnic and cultural roots
- Spiritual vitality



Sensitivity to the Senior's Reality

- Most seniors have strong social supports.
- Often resilient; they have coping skills to build upon.
- Living longer, continuing to develop intellectually, emotionally and spiritually.
- Less than 5% are in nursing homes or care facilities.
- Improved health status and access to health care.
- Informed consumers.
- Users of many “social” and community services



Most Seniors' Reality

- Normal aging is not depression, severe cognitive impairments, debilitating chronic diseases, or frequent hospitalizations.
- There are normal aging process changes, such as:
 - **sensory changes (e.g., hearing, vision)**
 - **mild cognitive changes (e.g., slowed thought processes)**
 - **age-related sleep patterns (e.g., needing less sleep)**
- A basic understanding of and training about the aging process and the risks, signs, symptoms and impact of alcohol and drugs is necessary when working with older adults.



Older Adults: Issues and Concerns

- People over age 65 take an average of 2-7 prescription medications per day.
- Over-the-counter drugs are often perceived as being “harmless.”
- Many people over the age of 60 are hospitalized due to undetected alcohol-related illnesses and trauma.
- Widowers over age 75 are the fastest growing group of alcoholics.
- By 2030, one in five people (or 20%) of people in the U.S. will be age 65 or older; this has enormous implications for the health care and substance abuse systems.



New York Seniors: Considerations Regarding Alcohol and Drugs



Decreased Tolerance in Geriatric Patients...

Diagnostic “adaptation” and sensitivity to mature adult

Absolute quantities of alcohol and / or drugs consumed / ingested may be relatively small and still bring on major complications.

- Slowed metabolic breakdown and elimination.
- pace/duration of detox, withdrawal, stabilization.
- Blood levels persist longer.
- “CNS”: Age-associated central nervous system sensitivity.



Most Commonly Prescribed Mood Altering Drugs

- **BENZODIAZEPENES**

- Ativan, Librium, Serax, Valium, Xanax
- For anxiety, insomnia and alcohol withdrawal
- Physiological dependence can occur even when taken at therapeutic dosage
- Benzodiazepene use for more than 4 months is not recommended for older adults

- **SEDATIVE / HYPNOTICS**

- Ambien, Dalmane, Halcion, and Restoril
- Most commonly prescribed for insomnia
- Physically addictive
- Sedative/hypnotic use for more than 30 days may be contraindicated

- **OPIOIDS**

- Codeine, Darvon, Demerol, Lortab, Percodan/Percocet
- Most commonly prescribed for pain control
- Rapid development of physiological dependence and tolerance



Over-the-Counter Medications With High Abuse Potential

- **ANTIHISTAMINES (taken as a sleeping aid)**
 - Benadryl, Tylenol PM, Unisom
 - Physical tolerance can develop within weeks
- **COLD/COUGH REMEDIES**
 - Many contain alcohol and other sedating agents (e.g., Nyquil)
- **ANALGESICS**
 - Aspirin, Tylenol, Advil, Motrin
 - Improper use can cause ulcers, internal bleeding

The potential for drug-drug and alcohol-drug interactions in older adults is especially high due to:

- Age-related physiological changes (unclear as to real source or course of problem)
- High probability: use more than one prescription and over-the-counter medication
- Co-existing chronic diseases (diagnosed / misdiagnosed / undiagnosed)
- Improper use of medications (deliberate or un-intended)



Over-the-Counter Drugs

- Significant use in geriatric population
- Arthritis, constipation, insomnia, coughs, allergies, etc.
- Incorrect belief that O - T - C drugs are “harmless” or “weak”



Alcoholism & Drug Addiction

- Primary chronic disease with genetic, psychosocial and environmental factors influencing its development and manifestations.
- Progressive and potentially fatal.
- Alcohol and / or Drugs - Impaired control, preoccupation with, use despite adverse consequences, and distortions in thinking, most notably denial.
- In the elderly, it might specify the late onset or continuation of behavior that becomes problematic because of physiological and psychosocial changes that occur with aging, including increased sensitivity to alcohol and drug effects.



Signs of Alcohol & Other Drug Abuse

- Unable to control amounts consumed.
- Preoccupation with activities involved in obtaining.
- Interferes with the normal daily functioning.
- Bio-psycho-social consequences of alcohol & drug misuse easily confused with problems associated with aging, such as falls or impaired cognitive function.



Medical notes:

1. Alcoholism / Addiction is a primary disease and not a secondary symptom of something else.
2. Various factors lead to a person's initial decision to drink or misuse a drug. However, once addicted, the addicted / alcoholic / dependent senior has a diagnosable disease with many consequences.
3. Get a diagnosis, make sure it's right and choose the best practices for the individual.



Clinical Subgroups:

Geriatric Alcohol & Drug Problems

- **Early onset - approximately 66%**
- **Late onset - approximately 33%**



Categories of Older Adult Alcohol & Drug Problems

- **AT RISK:**
Pattern of use with potential for adverse consequences
- **EARLY ONSET:**
Chronic substance abuse pattern (two thirds).
- **LATE ONSET:**
 - Tolerance for alcohol changes in older years;
 - Reaction to stressors in later years (one third).
 - Age of onset: 55 and older.
 - Average length of progression is rapid – can be as little as 1 year.
 - Less health problems, often intact families, stable employment history.
- **INTERMITTENT (Periodic):**
 - Similar characteristics to early onset abusers
 - Periods (sometimes lengthy) of abstinence from substances.



Dual-Diagnosis

- Chemical dependency with co-existing psychiatric disorders
- Chemical dependency with associated psychiatric symptoms
- Requires well managed, simultaneous services.



New York Seniors: Prevention & Education



SAMHSA Recommends Educating the Following Target Audiences:

- Older Adults
- Physicians and Other Health Care Professionals
- Senior Housing Managers
- Senior Citizen Center Workers
- Office for the Aging Staff
- Home Health Aides
- Clergy
- Adult Protective Services Workers
- Family Members



Prevention and Education

- Focus on health promotion that includes:
 - Stress Management
 - Medication Management
 - Depression Screening
 - Alcohol and drug use
 - Preconceived notions about drinks and drugs



SAMHSA recommends:

- **WARN:** Changes occur in the way the body works
- **ATTENTION!**
 - “You are still developing !”
 - Changes occur during retirement
 - “What do you want to become?”
- **BUILD:** Satisfying leisure activities throughout the life span.
 - “Pick one healthy thing to do today to make yourself feel better...and do it !”
- **FIND:** Support (groups) during difficult life transitions
 - e.g., bereavement, chronic medical condition
- **EDUCATE:** - about substance misuse and abuse in later *years*
 - to assist in identification and intervention with at-risk seniors
 - about risks and protective factors



Protective Factors

- Wisdom & Spirit
- No previous history of substance abuse
- No psychiatric problems/adequately treated psychiatric problems
- Proper pain management
- Adequate support; involvement in community, church or volunteer activities
- Ability to cope with losses without using alcohol or other drugs; spiritual beliefs
- One physician oversee health care
- Never combine alcohol and mood altering drugs
- No family history of substance abuse
- Support for care givers; respite care; recognizing one's own limitations



Risk Factors

- Previous history of alcohol or other drug abuse
- Untreated psychiatric problems (depression , anxiety)
- Chronic pain or Pain and / or Unsuccessful “pain management”
- Other limiting medical condition
- Limited social or family supports
- Bereavement and loss of other important relationships
- Having more than one prescribing physician
- Combining alcohol with mood altering drugs
- Family history of substance abuse
- Care giving responsibilities (e.g., for an ill relative, for a child or grandchild)
- Abuse, neglect, exploitation



Overcoming Potential Barriers:

- Physicians may unknowingly create and support barriers to intervening effectively.
- Physicians' minor interventions in their office or at the hospital can make a tremendous positive impact on an elderly patient.
- A doctor's intervention can be even more powerful and positive if made in the presence of informed family or friends.



SAMHSA notes in SAMHSA News, July/August 2004, Vol. 12, No.4

1. “There’s plenty of evidence demonstrating the effectiveness of various approaches to diagnosing and treating older people’s mental health problems... but (health care) providers don’t have the access to it.”
2. Some health care providers:
 - have misguided notions about older people and mental illness
 - sometimes assume that depression and anxiety are normal parts of the aging process
 - don’t even know that mental health problems can be treated



Barriers to Identification & Treatment

- Lack of knowledge or skills by professionals
- Stigma about aging, alcoholism and addiction
- Ageism
- Resistance & inability of family members to name a problem
- Denial - misunderstanding
- Symptoms of abuse mistakenly believed to be signs of aging
- Transportation to and from support sites, appointments, meetings, etc.
- Finances - insurance
- Sensory or mobility changes
- Co-occurring medical problems – holistic approach
- Co-occurring mental health problems – thorough diagnosis



Screening & Assessment



Screening

- In order to screen a senior for substance abuse problems, the screener must:
 - Know what to look for in a senior
 - Know how to screen a senior
 - Interpret specific information in terms of aging
 - Present no threats
 - Discuss the findings
 - Express a concern
 - Offer suggestions, options and support.



Considerations In Assessing a Mature Adult

- Does the senior have care giving responsibilities?
- What “nesting” or “rituals” surround a senior’s substance use?
- What is the quality of a senior’s intergenerational relationships?
- Consider the historical context of life’s personal experiences.
- Assess Activities of Daily Living (ADL).
- Storytelling helps a senior put his / her life into a meaningful context.
- With whom does the seniors live? WHY?
- Use open ended questions throughout assessment.



Criteria for Substance Dependence

3 out of 7 = a diagnosis of dependence

- Maladaptive pattern of substance abuse
- Clinically significant impairment
- Physical effects
- Control
 - Larger amounts than intended
 - Desire or unsuccessful efforts to cut down
 - Continued use despite problems, etc.
- Behaviors
 - Amount of time, effort and money spent to obtain
 - Reduction of social, job or fun activities, etc.
- Tolerance
 - How much does it take to achieve desired effect?
- Withdrawal
 - What happens when substance is stopped?

Diagnostic and Statistical Manual of Mental Disorder (DSM – IV) 4th Edition
American Psychiatric Association



DIAGNOSIS of GERIATRIC ADDICTION

Federal conclusion (SAMHSA)

Apply a flexible interpretation of the DSM-IV criteria considering the senior's pattern of alcohol use and the medical and social consequences on health.



Effective Screening & Assessment Tools for Use with Older Individuals

- RAPS - 4
- CAGE
- G-MAST
- Short G-MAST



Rapid Alcohol Problems Screen

RAPS-4 (4 Questions)

- During the last year have you had a feeling of guilt or remorse after drinking?

REMORSE

- During the last year has a friend or family member ever told you about things you did while you were drinking that you could not remember?

AMNESIA

- During the last year have you failed to do what was normally normally expected of you because of drinking?

PERFORM

- Do you sometimes take a drink in the morning when you first get up?

STARTER



C.A.G.E. Screening

- Have you ever felt you should Cut down on your drinking (or use of medication)?
- Have people Annoyed you by criticizing your drinking (or medication use)?
- 3. Have you ever felt “bad” or Guilty about your drinking (or medication) use?
- Have you ever had an Eye opener to steady your nerves or get rid of a hangover?

YES to 2 or more is significant and merits assessment for problem.

YES to 1 merits a discussion about relationship to substance(s)



ALCOHOLISM IN THE ELDERLY: DIAGNOSIS, TREATMENT, PREVENTION

American Medical Association - American Society of Addiction Medicine (ASAM) 1995

- In observing the role primary care physicians can play in better diagnosing alcoholism in their elderly patients and refer such patients for treatment ASAM notes:
 1. Alcoholism is a diagnosable medical condition that sends as many elderly Americans to the hospital as do heart attacks.
 2. Alcoholism among seniors takes a toll on society. Not only are the financial implications considerable, but more importantly it results in a tragic loss of productive years.
 3. Doctors may miss signs of alcohol abuse in their older patients
 4. Signs of alcoholism can mimic the symptoms of aging or Alzheimer's disease.
 5. Doctors identify the problem only 22% to 37% of actual cases seen in hospitals.

<http://www.asam.org/news/news1.htm>

Copies of AMA guidelines are available from the AMA at 1-800-262-3211



- It is particularly important to modify the *CAGE* questionnaire to detect drug abuse in older individuals, because elderly patients are prone to self-medication.
- The physician must be aware that cognitive impairment can affect the patient's ability to respond accurately to the questions.



Consider alcohol and drug use and the Medical Consequences on a Senior

Organ function

Risks:

- Hepatitis
- HIV
- STD

Orthopedics:

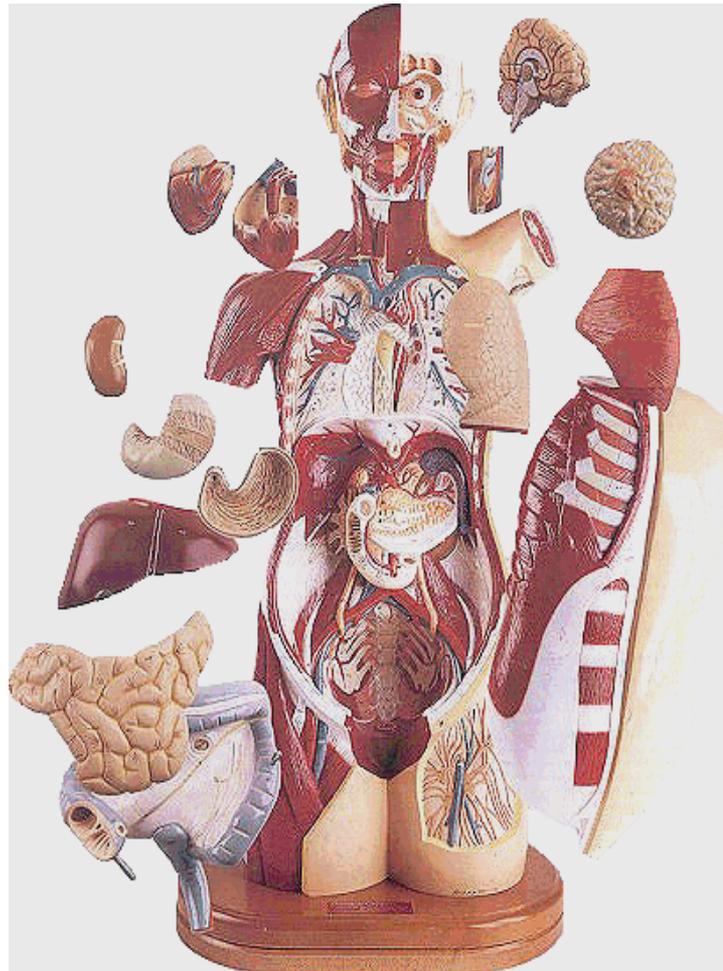
- Falls
- Twists
- Breaks

Continance

Pain

Lower extremities:

- Balance
- Pain
- Mobility



Central Nervous:

- Headache
- Neuropathy
- Tremors
- Tremens

Sleep Patterns

Prescriptions/OTC's:

- Interactions
- "Negation"

Heart

Digestion

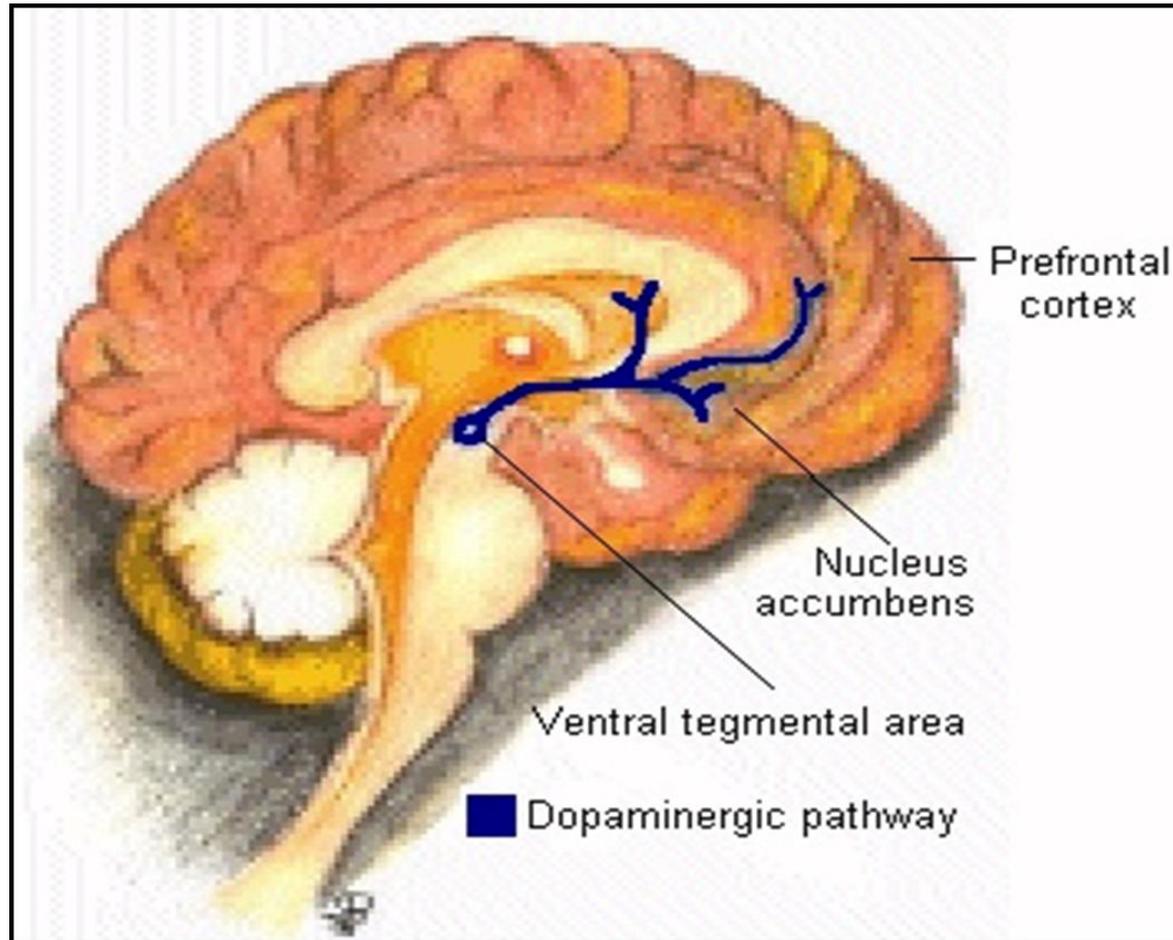
Blood pressure

Nutrition:

- Appetite



“It’s a brain disease....”



Social Considerations When Supporting Seniors in Treatment and Recovery

- Attention to and Understanding of
 - loss:
 - real, perceived, unexpected
 - depression:
 - assessment & diagnosis
 - loneliness
 - spiritual well-being:
 - "wisdom & growth"
 - aspirations and goals
 - potential for development



Intervention



Brief Intervention

- Various locations and settings where seniors can be reached:
 - Directly: one-on-one
 - Where you greet them:
 - your office
 - Go where they are:
 - Senior centers
 - Senior housing

Anyone can have an impact

One-on-one/In a group

Empower staff: in-service trainings and established protocols.



Intervention Strategies With Older Adult Substance Abusers

- **INTERVENTION:**
 - A process which helps interrupt the pattern of substance use.
 - Raises awareness of behaviors and risks associated with ongoing use.
 - Can provide a window of opportunity to move a person to consider options for change.
- **BRIEF INTERVENTION:**
 - Education; assessment;
 - Goal setting
 - Follow up visit(s) to assess progress toward achieving goals.
 - Appropriate for at-risk substance abusers and also as the beginning stage of the treatment process (pre-treatment).
 - Health care and senior services professionals are particularly valuable resources for conducting brief interventions.
 - Goal can be reduction of substance use, encouraging treatment, self help group participation, etc.



Intervention Strategies With Older Adult Substance Abusers

- INTERVENTIONS WHILE IN TREATMENT:
 - Interventions need to be made at different points during the treatment process – e.g., if denial or minimization begin to occur; if a relapse occurs; if the person has a medical, psychiatric or other need that requires a referral.
- STRUCTURED INTERVENTION:
 - Participants are briefed and trained beforehand and / or joined by an intervention specialist to share their concerns with the older adult.
 - Can include family members, service and health care professionals or others who are important to older adults. – avoid involvement of younger children / grandchildren.
 - Goal is to help older adult see the impact their substance use is having on themselves and those around them and to accept an option for assessment and / or referral.



Guidelines For Conducting An Intervention (1 of 2)

- Be informed about the process of substance abuse and recovery and have some options.
- Stress the connections between alcohol or other drug use and medical condition.
- Use personal “ I ” statements in a structured intervention ‘e.g.’
 - “When you drink, I feel...”
 - “When you take too many tranquilizers, I am concerned that...”
- Be non judgmental, non confrontational, and non threatening.



Guidelines For Conducting An Intervention (2 of 2)

- Avoid labels like “alcoholic”, “drug addict,” “drunk” and “addiction”.
- Be prepared to follow through with any bottom lines you mention.
 - “If you will work with us on a few suggestions, O.K. If not....”
- Be open, honest, direct and supportive throughout the intervention process.
- Be aware that mature adults have been raised with messages like:
 - “Don’t air your dirty laundry in public ”
 - “Men don’t cry ” (or express feelings)
 - “Don’t ask for help. Pick yourself up by your bootstraps”

These messages impact how older adults hear what you are saying.



Intervention Scenario: Guideline Questions

- What are the factual events and concerns that each person will present during meeting? (Physician? Caregiver? Family member? Friend?). Just stick to the facts.
- How will those concerns be conveyed to person during the intervention process?
- What will be the “bottom line” for each member of the intervention team if person refuses to acknowledge a problem with alcohol or medication?
- Is a treatment referral warranted?



The Intervention

- An interventionist needs to be:
 - Engaged
 - Prepared
 - Supportive
 - Empathetic
 - Clear
 - Objective
- The goal of intervention is to agree to something that will work to improve health.
- “Let’s see...given the facts, how do we offer some relief?”
- “What options have we got...you and me?”



TREATMENT



Helping Older Adults Make the First Step to Treatment

- The health care system is a ripe gateway to treatment.
- Family concern is a motivating factor
- If a health care professional informs an older person of the potential loss of independence, functioning and quality of life, motivation to change grows.



Meeting The Needs of Older Adults In Treatment

- Pace and duration of treatment plan
- Connection to trained & aware therapist
- Options for various therapeutic approaches
- Opportunities for socialization
- Peer support
- Holistic approach
- Case management
- Long term continuing care/aftercare



Treatment SUGGESTIONS..

- Groups:
 - Grief group
 - Leisure skills group
 - Life transition group
 - Reminiscent therapy group
 - Educational groups:
 - medical aspects of substance abuse;
 - mental health issues;
 - bereavement;
 - growing older with dignity, etc.



Therapeutic Modalities

Treatment of Older Adults

- Reminiscence therapy
- Peer Group
- Education Groups
- Special issues groups
- One-on-One Review and Updates: “How’s it going”?
- Family therapy
 - Begin with education;
 - group or individually; experienced family therapist for groups; encourage and discuss “self help” meeting (e.g. AlAnon) for family members
 - Ask that family members do not use alcohol or other mood altering drugs while participating in treatment (can help to identify a substance abuse problem in a family member).



Suggestions:

for modifying standard treatment models to better engage and impact an older patient.

- Provide frequent rest breaks and opportunities for socialization.
- Make sure lighting in the room is adequate.
- Reinforce educational information via verbal, visual and written format whenever possible.
- Provide long term continuing care.
- Having older adults in peer groups is ideal and desirable.



Outpatient Treatment

Suggestions for model:

- Ideally, 3 days a week
- “Seniors only”
- Trained and excited staff ... *all levels*
- Serious health problems limit intensity and frequency
- Allow time for and encourage participation in volunteering, work, family activities, medical appointments, etc.



Inpatient Treatment

- Progressive assessments should be made to determine a senior's physical stability, medical status, clarity of thought, comfort, and stamina.
- It is crucial to monitor the pace of physical, medical and mental change over time.
- Discharge
 - Refer for long term continuing care to an agency that is sensitive to the needs of older adults.



Risk Factors For Relapse

- Loneliness, boredom
- Chronic pain
- Unresolved grief
- Sleep disturbances
- Untreated mental health issues – e.g. depression, anxiety
- Lack of support for recovery
- Chronic medical problems
- Prolonged stress
- Difficulty in managing daily affairs – e.g. finances, chores
- Unsuitable living environment
- Lack of understanding about relapse or lack of a relapse prevention plan



Treatment:

- Special considerations to keep in mind when supporting a senior:
 - Out-of-Sequence Losses
 - Elder Abuse
 - Neglect
 - Exploitation
 - Cultural Considerations
 - Gender Issues



Out-of-Sequence Trauma and Losses

- Trauma and Losses that are not expected, such as:
 - Physical, emotional or sexual abuse results in loss of freedom, loss of innocence, loss of sense of safety, loss of trust, etc.
 - Death of a child
 - War
 - Terrorism
 - Natural Disasters



Elder Abuse

- Types Of Abuse:
 - Physical: includes use of physical force; inappropriate use of drugs or restraints; “punishing” elders for “misbehaving”
 - Emotional/psychological: includes verbal threats, intimidation; enforced social isolation; humiliation
 - Sexual: non consensual sexual contact of any kind. This also includes having sexual contact with a person incapable of giving consent.



Elder Neglect

- Elder Neglect:
 - Active neglect: Willful refusal of a caregiver to provide necessary services
 - Passive neglect: Non willful failure of a caregiver to provide access to services due to inadequate knowledge and lack of understanding of what is necessary
 - Self neglect: intentional or unintentional failure to follow medical directives and handle self care needs



Exploitation

- Exploitation:
 - Primary form of exploitation is financial.
 - Misuse of an older adult's funds, property or resources by another individual.
- Who are the perpetrators?
 - 90% of perpetrators are family members
 - 50% of the perpetrators are adult children
 - 20% are spouses
 - 9% are grandchildren
 - 9% are other family members.



Cultural & Other Considerations

- Aging Gay and Lesbian population:
 - Older generation still remembers and feels the strong stigma and discrimination affecting gay/lesbian people.
 - May still be “in the closet” and find it very difficult to share the reality of their lives, especially with heterosexual peers; may have been married and had children in an effort to conform to social standards.
 - May be uncomfortable with the openness of the younger generation of gays/lesbians.
 - Are facing the same issues and challenges of growing older and often have less family/social support; less comfortable housing options; limited rights (e.g. inheritance, health care decision making for a partner) or are living alone in far greater numbers than their heterosexual counterparts.



Concerns & Fears

- Some of the concerns and fears seniors report when thinking about treatment:
 - Treatment takes too long
 - It's embarrassing to tell people
 - Treatment is just for kids
 - Treatment is just for “hard core addicts”
 - Treatment is too expensive
 - Being away from home



Concerns & Fears

- Some of the concerns and fears seniors report regarding “12-Step” and “self-help” meeting attendance:
 - Being uncomfortable going out at night
 - Type of language used by some people at meetings (e.g. swearing, slang)
 - Appearance or location of the place where the meeting is held (e.g. having to walk through a crowd of people smoking outside the entrance to the meeting room; up/down stairs; loud sounds; hearing problems)
 - Not comfortable or used to talking about themselves
 - Some of the issues discussed at meetings (abuse, same-sex relationships, violence, etc.)
 - Afraid they might see or be seen by someone they know



Historical Considerations: Notes

- Some older adults remember stories about AA, which was founded in 1935, as a place needed only by “low bottom drunks.”
- Some seniors have a personal history of trying to get sober before and failing, despite their own best efforts and perhaps lots of help from others. Relapse is not clearly understood and needs to be.
- Not too long ago (before the 1960’s) many alcoholics were treated in psychiatric wards as a result of their presentation and behavior when drinking. Many older adults associate substance abuse treatment with this type of approach: being “locked up” or labeled “crazy”.
- Still strong stigma in the current generation of older adults about having a substance abuse problem: still viewed as a moral issue rather than a diagnosable medical condition.



Continuing Rehabilitation and Recovery In The Community

1. Seniors require multiple linkages to community services, agencies, and resources as well as healthcare providers.
2. No single treatment program can provide necessary range of continued service in community
3. When community-based services are not well-managed or not provided for an extended period of time, the rate of relapse is very high.
4. Effective case management Implementation of discharge plans.
5. Consider a senior's:
 - social network
 - proximity to and relation with family
 - real physical and mental limitations



Engaging Older Adults Through the Stages Of Change

1. PRE-CONTEMPLATION:

- o Person is not yet aware that they have a problem, however, someone in their life is concerned and has most likely talked to them.
- o Give information and raise awareness of a problem.

2. CONTEMPLATION:

- o A person begins to wrestle with changing a behavior or staying the same.
- o Counselor's task is to help motivate person to change by using motivational counseling techniques.

3. DETERMINATION:

- o A person makes a commitment to initiate action toward making a change.
- o Assist person to develop strategies, activities and skills necessary to accomplish



Engaging Older Adults Through the Stages Of Change

4. ACTION:

- o Person begins to make changes and take responsibility for their actions
- o support changes; offer feedback-particularly about successes.

5. MAINTENANCE:

- o A person continues to develop skills and strategies to maintain and build on changes made
- o Work with client on relapse prevention strategies.

6. RELAPSE

- o Person returns to old behaviors; this can be a powerful learning experience.
- o Help client not to become stuck; to renew commitment to change; to build on previous successes.



Relapse Prevention Strategies For Older Adults (1 of 2)

- Help clients develop meaningful leisure, social or vocational activities.
- Work with client and their physician on pain control strategies (ideally, non chemical ones).
- Address grief issues throughout treatment and refer for additional supportive services when needed.
- Teach clients good sleep habits (e.g. forego a daytime nap) and non chemical ways to cope with sleep disturbances.
- Be sure that mental health issues are being addressed and treated.



Relapse Prevention Strategies For Older Adults (2 of 2)

- Be sure client is keeping medical appointments, taking medications as prescribed and communicating changes in health status to physician.
- Teach stress management skills throughout treatment.
- Develop a relapse prevention plan tailored to the client's individual needs.
- Have a strong sober support system (e.g. 12 step meetings, church, family, close friends).



Seniors: Alcohol and other drugs Sources for additional information



US Department of Health & Human Services

Screening tests and procedures targeted at the elderly
are described in these publications:

Substance Abuse Among Older Adults.

Treatment Improvement Protocol (TIP) Series 26

Blow, F.C. Consensus Panel Chair. 1998.

DHHS Publication No. (SMA) 98-3179.

**Advances in alcohol screening and
brief intervention with older adults.**

Blow FC and Barry KL. 1999-2000. *Psychotherapy*. 10:107-124



“BEST PRACTICES” Federal Recommendations SAMHSA

Center for Substance Abuse Treatment (CSAT)
Treatment Considerations & Desk Manuals
Substance Abuse Among Older Adults”

Treatment Improvement Protocol [TIPS] Series

TIP Number 26

To order call Toll Free: 1 - 800 - 729-6686

Center for Substance Abuse Prevention (CSAP)

Online Prevention Materials

Free and friendly self-education course

web search: SAMHSA



Recommended video:

Substance Abuse in the Elderly

“ THE DOCTOR IS IN ”

Dartmouth-Hitchcock Medical Center. 28 minutes 40 seconds.

Available at:

<http://www.dartmouth.edu/~socy59/topics.html>

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