

*Teaching Workbook for*

**Practice in the Workplace**

**Maria Santiago's Story**

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## **Vignette-Maria Santiago**

The following vignette is based on an oral history of substance abuse conducted in a single interview by two social work students 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 alcohol and drugs. Only her name and identifying details have been changed.

### Description

Maria Santiago is a 63 year old woman of Hispanic descent, who has been in recovery from alcohol abuse for 20 years. She works as a discharge planning assistant at a large urban hospital. Many of the patients she sees are her age or older and some suffer from alcohol dependence. Two social work students interviewed her in a private office at the hospital, and found her to be friendly and forthright in discussing her experience with substance abuse. She "made steady eye contact with the interviewers and seemed pleased to share her history. Her tone of voice was calm and pleasant, and at times she made jokes, it seemed, as a way to divert from the sadness of her history." She is currently attending college and will receive her undergraduate degree in May, and hopes to become a full time counselor in substance abuse following her graduation.

### Family Background and Drinking History

Ms. Santiago never knew her biological father. When she was four years old her mother, "not a drinker," married a man whom she called "Daddy," an alcoholic whom she thought for several years was her father. He was affectionate to her while her mother was cold and critical; however, this affection soon took the form of sexual molestation. By the age of nine, she realized "something was wrong here," and she started trying to escape from him. For the next six years he was "always trying to rape me." When he was drunk and she resisted, he would physically abuse her as well, but not her stepsister who was five years older and his biological daughter. Finally when she was 15, his alcoholism became "so bad that he became abusive to my mother," and her mother left him. Throughout this period some extended family members were aware of the sexual abuse of Ms. Santiago, but were afraid to bring it to her mother who was in denial about it. Ms. Santiago, who also felt it was useless to tell her mother, was left feeling unprotected, depressed, and with "low self esteem."

During her adolescent years, her mother was very strict, but some drinking was allowed. “I couldn’t wear lipstick, or certain clothing. I couldn’t go out with friends, but I could have a drink in the house.” She attributes this seeming paradox to what she believes is a cultural acceptance of drinking among Hispanic people---especially for men, but for everyone “drinking is like a national pastime.” When people do drink to excess, it’s not talked about, nor is depression or other mental illness. In retrospect, she realizes that several male cousins were alcoholics and some died because of alcohol related illness or accident. But “no one talked about it and nobody ever went into treatment or detox that I know of.”

She began drinking seriously in her twenties, because “I was very shy and I found that alcohol let me be sociable, to talk with people...to go out, and to dance,” which she loved. “Without it I couldn’t because I was always afraid of people.” However, drinking also led to some “bad relationships.” At first she drank only on weekends, but gradually increased to daily drinking and by the time she was 29 she realized she “had a problem.” She drank mostly rum but sometimes used diet pills or even cocaine because they “enabled me to drink longer.” She soon stopped the pills and cocaine, thinking those were the problem. “There was more shame to admitting that I had a problem with alcohol, than a problem with pills.”

During her twenties, Ms. Santiago had three sons and says that despite her drinking, she “managed not to lose my children or my job.” Still there were problems, especially as her drinking “took off” during her thirties. She called in sick more frequently, using up her sick days and vacation days. She fell behind in her bills. As her children grew, she felt she was losing control over them. She also was aware that she had lost control of her drinking. “To cope with anything that was going on... I had to have it bad.”

Finally as she approached 40, after 10 years of very heavy drinking, she became a “blackout drinker,” sometimes getting hurt and waking up in strange places with no memory of how she got there. This frightened her. Her boyfriend at the time, also a drinker, threatened to leave her because “I drank too much and couldn’t keep my word.”

### The Road to Sobriety

At the age of 40 she attended her first AA meeting to appease her boyfriend, with no real intention of stopping her drinking. She persuaded her boyfriend to accompany her hoping that “if he went to the meeting with me, he’d stay with me.” She felt shame entering the church basement where the meeting was held, “thinking someone from the neighborhood would see me.

Never mind how many times people probably saw me coming home drunk. I didn't think about that." The boyfriend never went back after the first meeting and soon thereafter they broke up, but Ms. Santiago kept going to AA despite her embarrassment, because she "knew I couldn't drink anymore. I was getting scared; I was getting hurt; I was afraid something would happen to my kids one day when I was drunk."

She detoxed on her own, not knowing that there were facilities to help her with detox or rehab. The following year she did enter psychotherapy at a community mental health clinic, and found it helped her to recognize her depression and to understand the causes and triggers of her drinking. She has continued to go back to therapy in times of stress and has attended AA meetings weekly for the last 20 years.

Recovery remains difficult, so she structures her life carefully to avoid relapsing. Initially, she had to stay away from friends who drank and to stop attending their parties. "It was like going through the stages of grief." She suffered months of loneliness before making new friends through AA, with whom she could go to dinner and sober dances. Temptation to drink is always present, so she tries to avoid triggers, such as those signified by the acronym H.A.L.T., which stands for being Hungry, Angry, Lonely, or Tired. Above all, she continues to "work on 'the Steps' ...to go on retreats, including religious retreats...and to surround myself with people who don't drink." In addition she advises, "Don't go to places where there's drinking...if you find yourself in a place with drinking and you feel uncomfortable, leave... and if temptation is too great, call your sponsor."

Her children and grandchildren have been supportive of her recovery and this has helped her maintain it. Her oldest son, who grew up during Ms. Santiago's heaviest drinking years, drank too much for a while, but "he admitted he had a problem," and she helped him get help. He died a few years later of cancer, but Ms. Santiago takes comfort in the fact that before he became ill he was alcohol free and "doing real good." Also, she was then strong and able to care for him in his final illness. Her youngest son, 10 years younger than the oldest, is a policeman and stays on "the straight and narrow." Recognizing her part in her sons' attitudes toward liquor, Ms. Santiago adds, "[Fortunately] I went into recovery when my youngest was 10 years old." This son and a 21 year old grandson have accompanied her to meetings and especially to her anniversary events.

She never told her mother about how far her drinking had gone or about her entering recovery. “She didn’t want to hear about things like that. She always said I wasn’t going to amount to anything... so I would never tell her that.” Ms. Santiago told only a few of her cousins because most of them “would see it as a failure. They don’t understand the concept of recovery.”

#### The Legacy of Alcohol Abuse

Five years into her recovery after a series of gynecological infections, a hysterectomy and severe weight loss, Ms. Santiago was diagnosed with HIV, which she realized in retrospect she contracted years earlier from a man she “met drinking.” She blames her alcohol-impaired judgment, “plus no one ever taught me how to protect myself. That’s cultural, too.”

She initially found the medical bureaucracy unresponsive and unsympathetic. While her T cells dropped and she felt sicker, it took her a month to get an appointment for treatment. Then she had to fight to be included in a study for a new medication which helped “turn me around.” Later she had to push for changes in her drug regimen because of severe side effects—including three years of bad nightmares with one drug. Currently she has gained back her weight and her T cells and is taking just one drug for her HIV. In the meantime she has developed congestive heart failure, for which she also takes medicine, and is aware that either of these illnesses may well shorten her life. On the positive side, she has learned to be proactive in getting help from doctors and hospitals, and has become active with an AIDS advocacy organization to help others get needed help. Her boss is aware of her health problems; others at her job are not.

She feels grateful that she never developed cirrhosis of the liver and was never drawn into any illegal activity, so she was never arrested. She also thanks God that “I haven’t had a relapse, because the minute I pick up that drink, the school goes, the job goes and forget about my health.”

Now she is enjoying life and catching up on all the things she didn’t do or couldn’t afford in her drinking years—going to college, taking vacations, buying clothes, fixing up her apartment.

#### Alcohol abuse and aging

When Ms. Santiago first went into recovery, she thought she would only have to go to meetings “for a while... that by the time I was 60 or 65, no one would care if I did drink. Now I realize that *I care*. I don’t want my sons to be picking me up off the street somewhere. Also I already have congestive heart failure. If I pick up a drink I’m going to have a heart attack, or a

seizure or a stroke, who knows?" She knows now that she will be going to AA meetings for the rest of her life.

In her job as a discharge planning assistant, she has seen homeless alcoholics who have convulsions, with no one to take care of them. "It's frightening."

She is more confident of her ability to resist drinking now. "I used to worry about what people would think of me if I refused a drink or had to explain myself. Now I don't care so much what people think of me... I have to take care of myself..."

It's never too late to stop. Some people don't try because they think about all those years they lost. But you've got to think about the years that you have left, how you can live them productively. You know, I'm doing a lot of things that I didn't do before. Getting old is hard enough. I want to live as much as I can!"

## **Teaching Guide—Maria Santiago**

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—Maria Santiago**

### **KEY ELEMENTS AND THEMES IN THIS VIGNETTE**

1. Personal history of addiction as a potential asset when working in the addiction field provided the professional is self aware.
2. The possibility of hope for recovery at any age or stage of life.
3. The connection between trauma and addiction, especially in women, with frequently resulting shame, low self-esteem and depression.
4. The possibility that women with history of substance abuse and early trauma are involved in unhealthy adult relationships which may intrude on the workplace in times of conflict between the partners.
5. How addictions impact addicts in multiple domains of functioning, including work responsibilities, health and family
6. The interplay between substance abuse and work across the lifespan
7. The impact on individuals of cultural beliefs that drinking is less dangerous than use of illegal drugs.
8. The influence of cultural norms surrounding substance abuse and/or mental health issues and how these norms might influence substance use and help-seeking behavior.
9. How help-seeking behaviors differ by gender, race and ethnicity.
10. How shame prevents many people from asking for or accepting help with substance abuse issues
11. The role that the non-abusing, non-alcoholic parental partner and extended family may play in maintaining the dysfunctional family system
12. Individual and social factors that account for ongoing sobriety among substance users
13. The importance of social support and of being able to distinguish between people who are supportive and valuable to one's recovery and people who are not
14. The role of 12 step self-help programs in creating a non-using support network for people in recovery.
15. Issues of worker disclosure of substance abuse and/or HIV status to colleagues, to supervisors or to clients. When is it advised or not advised?

16. Supervisors' obligations (if aware of workers' substance abuse or HIV status) in hiring and firing decisions, in making "reasonable accommodations," and in maintaining worker confidentiality
17. The workplace as a setting for micro and macro interventions around substance abuse

### **SUGGESTED CLASSROOM AND HOMEWORK EXERCISES**

1. Have students research the literature about cultural norms around drinking and around mental health problems among Hispanic people. Is Ms. Santiago's perception of her culture's beliefs consistent with the literature? Are there variations in such norms among people from different Latin countries?
2. Have students research the literature about cultural norms around drinking among persons of a race or culture (different from their own) that is represented among clients their agencies serve.
3. Have students create a genogram for Ms. Santiago.
4. In groups, students can consider the following scenario:
  - What if you were an employee counselor at this hospital asked to see Ms. Santiago during her late 20's and early 30's when she began calling in sick frequently and showing some signs of carelessness on her job, though her referring supervisor hadn't mentioned suspicion of a drinking problem? How would you conduct a biopsychosocial assessment, including a substance abuse assessment? If you thought she had a substance abuse disorder, what would you do next? What if she denied your assessment and didn't want help?
  - Two members of the group could role play the discussion between the counselor and Ms. Santiago.
5. In groups, design a substance abuse awareness and education program for employees of the hospital where Ms. Santiago works. The program should include information about the nature and symptoms of substance abuse, high risk behaviors and should normalize help seeking behavior. Include considerations of how to address the various cultural groups among the employees.

If there had been such a program in place at any point in Ms. Santiago's working life, would that have made a difference in the course of her substance use?

6. Assign students to review the literature on the differential risks for substance abuse among survivors of childhood sexual abuse and/or the treatment literature on how to respond to women with substance abuse and abuse histories. Using the self-medication hypothesis students could be asked to write papers on the etiology and treatment of substance abuse in women or to share thoughts on this in class discussion.
7. Assign readings from the empirical literature on factors associated with and supportive of long-term recovery, as well as the literature on treatment designed to support recovery and prevent relapse.
8. Invite a guest speaker from an EAP program to talk about issues related to work and substance abuse and the interventions available to a supervisor and to an EAP worker.
9. Suggested article:

Pooler, D.K., Faul, A.C. & Huber, R. (2008) Personal history and professional impairment: Implications for social workers and their employers. *Administration in Social Work*, 32(2) 69-85.

### **DISCUSSION QUESTIONS**

1. Using the case of Ms. Santiago, describe the interplay between family, substance use and work across the lifespan.
2. How can you apply the case of Ms. Santiago to your understanding of assessment and intervention with substance abuse in the workplace—whether younger or older workers?
3. What are some of the benefits and risks of having recovering substance abusers on the staff of a hospital as discharge planners?
4. What are some of the benefits and risks of having recovering substance abusers on staffs of treatment programs? Consider the values and risks for the program, the clients and the recovering counselor? What policies and procedures might an agency take to maximize the benefit and reduce the risk of having recovering substance abusers on treatment teams?

5. Ms. Santiago for most of her drinking life was a “functional alcoholic.” Discuss how this promotes denial and affects efforts at intervention.
6. How might cultural factors –normalizing of drinking, reluctance to seek help for “mental problems”—affect an EAP counselor’s ability to intervene? If you were an EAP counselor asked to see Ms. Santiago during her heaviest drinking period, how might you approach her? Is it important to know which Hispanic country she came from?
7. How might beliefs about drinking and seeking help for substance abuse differ for people who are Hispanic, African-American, Asian or American-Indian? How might beliefs of these groups differ from those of groups descended from various European cultures?
8. AA, a kind of self-help group, was extremely helpful for Ms. Santiago, though she at first felt shame about attending. For whom do self-help groups tend to work and for whom do they not? Should the hospital where Ms. Santiago works host an AA group on the premises?
9. “Giving back” or helping others is a part of AA philosophy and is thought to enhance mental health and recovery. Since Ms. Santiago has now disclosed to her colleagues and employer that she has been in recovery for 19 years, should the hospital social service department give her opportunities to speak to patient or staff groups about alcohol abuse?
10. Given what we know about the factors associated with long-term recovery and relapse prevention, what role can the work place play in supporting Ms. Santiago’s long-term recovery?
11. Ms. Santiago’s boss is aware of her HIV status. How might this knowledge affect the boss’s expectations and their working relationship? Should workers be obliged to disclose their health conditions to their employers? Should they be obliged to disclose their substance abuse history? If the employer has knowledge of either of these things, what should he or she do differently from current supervisory practice?
12. Should people with histories of substance abuse or HIV disclose these to colleagues? To clients? If yes, under what circumstances? Discuss the values behind your recommendation.
13. Ms. Santiago is 63 years old. What do you think of her educational and career aspirations, given her age and health status? What are the values underlying your position? If you

were her employer and had an opening in your substance abuse treatment team, after she met the educational requirements, would you offer her a job?

## **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.
- 9. Conduct assessment and intervention strategies for substance/drug/alcohol abuse in later life.**
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.**

- 17. Understand differential assessment and intervention strategies associated with early onset and late onset substance abuse.**
- 18. Understand and be able to implement motivational strategies relevant to older persons with substance abuse/misuse concerns.
- 19. Be able to identify, locate and appraise quality of empirical evidence supporting assessment and intervention in older persons with substance abuse/misuse problems.**
- 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).

Additional Sources: Blow (1998), Brown & Lewis (1999), Guida et al. (2004), Hanson & Gutheil (2004), Menninger (2002), Patterson & Jeste (1999)

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## Resource Materials

<u>Resource</u>	<u>Obtained from</u>
Fact Sheet #1: Myths and Realities of Alcohol, Medications, and Mental Health Issues in Older Adults	U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. (2003). <i>Get Connected! Linking Older Americans With Medication, Alcohol, and Mental Health Resources</i> (DHHS Pub. No. SMA 03-3824). Rockville, MD: Author. Downloaded from <a href="http://download.ncadi.samhsa.gov/prevline/pdfs/getconnectedtoolkit.pdf">http://download.ncadi.samhsa.gov/prevline/pdfs/getconnectedtoolkit.pdf</a>
Fact Sheet #2: The Safe Use of Alcohol and Medications: Tips for Older Adults	U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. (2003). <i>Get Connected! Linking Older Americans With Medication, Alcohol, and Mental Health Resource</i> . (DHHS Pub. No. SMA 03-3824). Rockville, MD: Author. Downloaded from <a href="http://download.ncadi.samhsa.gov/prevline/pdfs/getconnectedtoolkit.pdf">http://download.ncadi.samhsa.gov/prevline/pdfs/getconnectedtoolkit.pdf</a>
Fact Sheet #3: Preventing Medication and Alcohol Misuse Among Older Adults	U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. (2003) <i>Get Connected! Linking Older Americans With Medication, Alcohol, and Mental Health Resource</i> . (DHHS Pub. No. SMA 03-3824). Rockville, MD: Author. Downloaded from <a href="http://download.ncadi.samhsa.gov/prevline/pdfs/getconnectedtoolkit.pdf">http://download.ncadi.samhsa.gov/prevline/pdfs/getconnectedtoolkit.pdf</a>
Fact Sheet #4: An Invisible Problem: Alcohol and Older Adults	U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. (2003). <i>Get Connected! Linking Older Americans With Medication, Alcohol, and Mental Health Resource</i> (DHHS Pub. No. SMA 03-3824). Rockville, MD: Author. Downloaded from <a href="http://download.ncadi.samhsa.gov/prevline/pdfs/getconnectedtoolkit.pdf">http://download.ncadi.samhsa.gov/prevline/pdfs/getconnectedtoolkit.pdf</a>
Fact Sheet #6: Prescription and Over-the-Counter Medications and Older Adults	U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. (2003). <i>Get Connected! Linking Older Americans With Medication, Alcohol, and Mental Health Resource</i> (DHHS Pub. No. SMA 03-3824). Rockville, MD: Author. Downloaded from <a href="http://download.ncadi.samhsa.gov/prevline/pdfs/getconnectedtoolkit.pdf">http://download.ncadi.samhsa.gov/prevline/pdfs/getconnectedtoolkit.pdf</a>
Medication Misuse Among Older Adults	Ohio State University Extension. (2001). <i>Medication Misuse Among Older Adults</i> (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>
Common Adverse Effects of Medications for Older Adults	U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. (2003). <i>CSAP's Prevention Pathways: Online Courses. Module 3. Prescription and Over-the Counter Medications</i> . Downloaded from <a href="http://pathwayscourses.samhsa.gov/aaac/aaac_3_pg9.htm">http://pathwayscourses.samhsa.gov/aaac/aaac_3_pg9.htm</a>
Common Side Effects of Over-the-Counter Medications for Older Adults	U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. (2003). <i>CSAP's Prevention Pathways: Online Courses. Module 3. Prescription and Over-the Counter Medications</i> . Downloaded from <a href="http://pathwayscourses.samhsa.gov/aaac/aaac_3_pg11.htm">http://pathwayscourses.samhsa.gov/aaac/aaac_3_pg11.htm</a>

<u>Resource</u>	<u>Obtained from</u>
Alcohol Use Screening and Assessment for Older Adults	Naegle, M.A. (2007). Alcohol use screening and assessment for older adults. In Hartford Institute for Geriatric Nursing, New York University College of Nursing. <i>Try This 17</i> . Downloaded from <a href="http://www.hartfordign.org/publications/trythis/issue17.pdf">http://www.hartfordign.org/publications/trythis/issue17.pdf</a>
CAGE Questionnaire – Screen for Alcohol Misuse	Downloaded from <a href="http://www.whoguidemhpcuk.org/downloads/primary_care/11-1_CAGE_questionnaire.pdf">http://www.whoguidemhpcuk.org/downloads/primary_care/11-1_CAGE_questionnaire.pdf</a>
The Alcohol Use Disorders Identification Test (AUDIT): Interview Version	Babor, T.F., Higgins-Biddle, J.C., Saunders, J.B. & Monteiro, M.G. (2001). AUDIT: The Alcohol Use Disorders Identification Test, Guidelines for use in primary care (2nd ed.). Geneva, Switzerland: World Health Organization, Department of Mental Health and Substance Dependence, p.17. Downloaded from <a href="http://whqlibdoc.who.int/hq/2001/WHO_MSD_MSB_01.6a.pdf">http://whqlibdoc.who.int/hq/2001/WHO_MSD_MSB_01.6a.pdf</a>
The Geriatric Depression Scale (GDS)	Kurlowicz, L. & Greenberg, S. A. (2007). The Geriatric Depression Scale (GDS). In Hartford Institute for Geriatric Nursing, New York University College of Nursing. <i>Try This 4</i> . Downloaded from <a href="http://www.hartfordign.org/publications/trythis/issue04.pdf">http://www.hartfordign.org/publications/trythis/issue04.pdf</a>
Beers' Criteria for Potentially Inappropriate Medication Use in the Elderly	Molony, Sheila L. (n.d.). Beers' criteria for potentially inappropriate medication use in the elderly. In Hartford Institute for Geriatric Nursing, New York University College of Nursing. <i>Try This 16</i> . Downloaded from <a href="http://www.hartfordign.org/publications/trythis/issue16.pdf">http://www.hartfordign.org/publications/trythis/issue16.pdf</a>
Prevention of Medication Misuse in Older Adults	Older Americans Substance Abuse & Mental Health Technical Assistance Center. (n.d.). <i>Prevention of medication misuse in older adults</i> . Downloaded from <a href="http://www.samhsa.gov/OlderAdultsTAC/docs/Medication_Booklet.pdf">http://www.samhsa.gov/OlderAdultsTAC/docs/Medication_Booklet.pdf</a>
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