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SUBSTANCE ABUSE TREATMENT FOR OLDER ADULTS: SOME PRACTICAL CONSIDERATIONS

Maurice S. Fisher, Sr., PhD, LCSW, ACSW

IN THIS ISSUE

Older persons often resist the idea of substance abuse treatment, and family members frequently deny the diagnosis. Moreover, because symptoms of substance abuse are similar to other age-related disorders and the subject is uncomfortable, medical professionals sometimes misdiagnose addiction. Developing and designing effective substance abuse treatment programs for older persons requires adopting a developmental perspective that is acceptable and functional.

The overall design of the treatment program will have to develop so that they incorporate numerous interventive aspects. First, detoxification and treatment for older adult patients require a slower-paced process because of medical, cognitive, psychological, and other factors associated with aging (Colleran, 2009). Second, comprehensive treatment should be rooted in a combination of disease and recovery (i.e., a 12-Step philosophy) along with a cognitive-behavioral approach to focus on specific skill development. Third, the treatment approach for older persons needs to be culturally relative and respectful of their generational values and world outlook. These beliefs include moral judgments about illegal drugs and people who use them, a respect for authority figures, and pride in handling one's own problems (Colleran, 2009). Fourth, treating clinicians should avoid words and phrases that are stigmatizing—even labels such as alcoholism and addiction carry a tremendous stigma, especially for older people. Keeping demographic-specific values and taboos in mind when intervening with older adults is critical in creating a therapeutic alliance and treatment environment. Older adults are typically more comfortable sharing life stories and accepting support and treatment interventions when they participate with peer groups (Colleran, 2009). Thus, an intergenerational group approach would be contraindicated due to the potentiality of unwarranted confrontations that possibly would have a "chilling effect" on older persons feeling free to share and risk in treatment.

A fifth aspect to substance abuse treatment with older adults is the use of basic education on the interactive effects of prescribed medications. Sixth, the net impact of using and abusing alcohol either singularly or in

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Letter From the **Chair**

Maurice S. Fisher, Sr., PhD, LCSW, ACSW
Chair, ATOD Practice Section

A somewhat forgotten population of persons who have various substance abuse and dependency problems is our older citizens. This is an overlooked, and often ignored, group because they typically are not assumed to have substance abuse problems (by virtue of their age, lived experiences, and maturity) and because we generally don't like to think of people in this age cohort as having an addiction. Additionally, like many others who abuse various substances, older people have an uncanny way of hiding their use, underreporting their use, minimizing their use, and projecting blame onto others for their abuse (such as health care providers and caretakers).

Moreover, significant others and family members tend to underrespond and even ignore older persons' abuse, misuse, and dependency on over-the-counter, licit (e.g., alcohol), and illicit drugs. In fact there are some family members and peers who are aware of the older person's abuse and/or dependency problem, but rationalize that they have a de facto "earned right" to be irresponsible with substances by virtue of being old. But, many older people do regularly have major substance use problems, and these problems not only directly affect them but have deleterious effects on those who love and care for them.

Frequently the problem is that older people are iatrogenically addicted by well-meaning medical professionals (who seek to "first do no harm" where a reduction in reported pain and suffering is a primary goal). Furthermore, older people frequently turn to various substances as a way to cope with painful emotional features, such as losses in their lives and difficult chronic medical problems. They also may have developed maladaptive coping mechanisms early in life that have carried on through adulthood.

The problem of older persons being addicted has reached a critical point, due to the aging of the baby boomers. Many baby boomers have entered their senior years having had a history of abuse and addictive patterns in their lives as younger people, thus compounding addiction problems in latter years.

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combination with prescribed and over-the-counter medications needs to be addressed. Seventh is the development of age-linked coping mechanisms and grief management skills to address life losses (e.g., deaths of significant loved ones and peers) through both therapy and support groups. An eighth element of cogent treatment is enhanced family involvement in therapy because it is paramount to addressing the older person's substance abuse problems. And, finally, the development of an individualized recovery plan that factors in the developmental issues with which older people grapple must be directly addressed—barriers and obstacles such as mobility, health issues, family support and involvement, and financial limitations.

In sum, older adults have proven to be relatively successful in substance abuse treatment among all age groups (SAMHSA, 2008). When factoring these treatment suggestions into a comprehensive treatment protocol, the results and outcomes should be increasingly efficacious.

Maurice S. Fisher, Sr., PhD, LCSW, ACSW, chairs the NASW Alcohol, Tobacco, and Other Drugs Specialty Practice Section.

References

Colleran, Carol. (2009). Substance abuse in older adults. *Aging Well*. Retrieved from www.agingwellmag.com/news/exclusive_02.shtml.

Substance Abuse and Mental Health Services Administration (SAMHSA). (2008). Rockville, MD: United States Department of Health and Human Services.

(From the Chair, continued from page 2)

This edition of the ATOD Section newsletter discusses some of the fundamental issues associated with what we believe is a growing national problem that needs to be addressed. As social workers involved in the evaluation and treatment of substance addictions, this ATOD Section newsletter will certainly add to our understanding of the severity of the problems associated with older persons' substance use and, I hope, stimulate our clinical case conceptualizations.

Best regards,

Maurice S. Fisher, Sr., PhD, LCSW, ACSW

GRIEF AND LOSS: NUMBING THE PAIN THROUGH SUBSTANCE USE

Jessica Holton, MSW, LCSW, LCAS

Imagine having a person in your life for more than 30 years who was your main supporter, your best friend, and your partner. Now, picture that same person becoming terminally ill. How would you cope, knowing the individual's remaining lifespan has been reduced to less than six months? Would you use adaptive coping skills or maladaptive coping skills? Envision, after being the main caregiver of that person for the past four months, that person dying. How would you cope? Would you allow yourself to grieve? How long would you permit yourself to grieve?

Throughout the lifespan, individuals will experience a variety of emotional upsets, including job changes, forced relocation, physical and/or emotional disability, chronic illness, the end of relationships, financial anguish, and death of a loved one (Chapman, 2009). Whether the individual is a child or an older adult, it is essential that he or she work through and grieve the various struggles. If such struggles are ignored and avoided, the grieving becomes more complex as one moves through the lifespan. One method of avoidance, or maladaptive coping, is substance use or abuse.

Older adults, presently known as the "baby boomers" (individuals born between 1946 and 1964), are expected to place increasing demands on the substance abuse treatment system in the next two decades. It is estimated that the number of substance dependent people will increase in this population from approximately 1.7 million in 2001 to 4.4 million by 2020 (SAMHSA, 2007). As individuals age, the following risk factors could contribute to substance abuse and substance dependence: death of spouse, friends, and other family members; loss of income, social status, and self-esteem as a result of retirement; loss of mobility regarding transportation; impaired vision and hearing; insomnia; memory problems; declining health secondary to chronic illness; separation from children and loss of home resulting from relocation; and loss of social support and activities of interest. Older adults trying to adjust to the above losses may use or abuse alcohol, or other substances, as a means of coping (SAMHSA, 2003).

In order to prevent substance use from being the method of choice for coping with loss, it is crucial to understand, work through, and grieve each loss. The following model regarding grieving was created by Elisabeth Kubler-Ross, which was published in her book *Death & Dying* in 1969. This model has five stages and serves as a dynamic guide to grieving (Chapman, 2009). The five stages are 1) denial, 2) anger, 3) bargaining, 4) depression, and 5) acceptance. It is important to realize that everyone grieves differently. Acute grief typically takes 12 to 18 months, in which the individual might exhibit several of the stages at one time. This grief is very painful and confusing for most individuals, thus using maladaptive coping skills, such as alcohol, often occurs. After the acute grief lifts, the individual appears to understand and work through the stages of grief more smoothly.

- Denial is a natural defense mechanism that can become harmful if used frequently. It consists of consciously, or unconsciously, refusing to accept facts, information, and/or reality that is directly related to the event. This stage is often short in duration; however, some individuals can become locked in this stage.

- Anger can present itself in various ways depending on the person and his or her anger style. During this stage, the anger is often projected onto an external source, such as a doctor, a family member, or even a Higher Power.

- During bargaining, the person moves from projecting anger onto others to negotiating a compromise. The compromise might be with self, a loved one, or a Higher Power. For example, if someone is grieving the death of a loved one, the person might ask his Higher Power to take him and allow the loved one to live. If the person is struggling with loss of independence, he might volunteer to do more for others. Often times, this stage involves, "what ifs" and "I should have, could have, would have."

- While working through the stage of depression, the person begins to focus on self and the emotions he feels regarding the loss. He often will feel sadness, guilt, regret, fear, and uncertainty. The person often does not appear clinically depressed; rather he appears to have "the blues," or will report feeling "blah."

- Acceptance is the final stage. In this stage, people often feel a sense of peace and balance.

It is not uncommon for individuals to revisit the anger, bargaining, and depression stages multiple times before they reach acceptance. Informing individuals that there are many layers to the event they are grieving is necessary. More often than not, the individuals will state that they have accepted the death or loss, in which they have only accepted the physical death or loss. They have not, however, worked through and grieved the loss of tradition, loss of interaction, loss of future goals, celebrations, birthdays, and anniversaries.

The grieving process is complex and layered, in which movement will become stagnant if the individual is using alcohol and/or drugs to numb the pain of grief and loss. It is essential to treat the grief and loss in conjunction with the chemical use. For some individuals, specifically individuals who are misusing or abusing chemicals, discussing and explaining the grieving processes might assist them in decreasing their chemical use. For some who are chemically dependent, ceasing the chemical use prior to implementing the grief work might be necessary.

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References

Chapman, A. (2009). *Kubler-Ross model for death and bereavement counseling, personal change and trauma.* Retrieved from www.businessballs.com/elisabeth_kubler_ross_five_stages_of_grief.htm.

Substance Abuse and Mental Health Services Administration. (2003). *Get connected! Linking older Americans with medication, alcohol, and mental health resources.* Department of Health and Human Services Publication No. (SMA) 03-3824. Rockville, MD: Author.

Substance Abuse and Mental Health Services Administration, Office of Applied Studies. (2007, November). *The DASIS report: Older adults in substance abuse treatment: 2005.* Rockville, MD: Author.

DRUG ABUSE, MISUSE, AND DEPENDENCY INCREASING AMONG OLDER ADULTS

Maurice S. Fisher, Sr., PhD, LCSW, ACSW

Alcohol and illicit drug abuse in the United States has historically been associated with young populations. Traditionally, many studies have shown rates of problematic use to decline with increasing age, starting in the mid- to late 20s (SAMHSA, 2008). This is primarily due to reduced use of both alcohol and illicit drugs by people as they age. When people are in their 20s and 30s, the reduced use is related to significant shifts in responsibilities and preventative factors, such as having a regular job, marriage, and parenthood. The continued reductions in prevalence rates at later ages could be related to "aging out" or to elevated mortality rates among substance abusers.

However, birth cohorts that experience high rates of illicit drug use in youth have subsequently shown higher rates of use and associated problems as they age, relative to other cohorts (SAMHSA, 2008). Illicit drug use in the United States was rare in cohorts immediately preceding the baby-boom cohort, defined as those born from 1946 to 1964. The rate peaked in 1979, when the baby-boom cohort was ages 15-33. During that peak year, approximately 10% of the estimated 25 million current illicit drug users were age 35 or older. In 1995, when the baby-boom cohort was ages 31-49, the percentage of current illicit drug users who were over the age of 34 had increased to 27%. In 1995, 49% of the baby-boom cohort reported having ever used

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illicit drugs in their lifetime, compared to only 11% of adults aged 50 and older (Gfroerer, Penne, Pemberton, & Folsom, 2002). Rates of heavy alcohol use have also been shown to be higher among baby boomers than in earlier cohorts. In addition to being more likely to be illicit drug and heavy alcohol users than previous cohorts, the baby-boom cohort is larger than earlier cohorts.

These data suggest that the prevalence of problematic substance use among older adults may increase as the baby-boom cohort ages. In 1996, the oldest members of the baby-boom cohort reached age 50. In 1998, only 7% of admissions to publicly funded substance abuse treatment programs involved patients age 50 or older (SAMHSA, 2008). The higher rates of problematic substance abuse among the baby-boom cohort will likely lead to an increase in this number. This will require a shift in focus for treatment programs, which have dealt primarily with young populations, in order to address the special needs of an older population of substance abusers.

Information on the size and nature of this potential shift in treatment need is critical to treatment planners and policymakers. In 2020, the 50-and-older age group will include all of the surviving baby boomers as well as a post-baby-boom cohort (born 1965 to 1970) that also experienced a high rate of illicit drug use during youth (Gfroerer et al., 2002; NSDUH, 2010).

More recently, admission of older adults (age 50 and older) for substance abuse treatment has substantially increased by 32% from 1995 to 2005 (Moran, 2005; SAMHSA, 2008). Though substance abuse is still more common among younger adults (aged 18 to 49) than older adults (aged 50 and older), licit (e.g., alcohol and over-the-counter medication, such as sleep aids) and illicit drugs appear to be increasing among our older population (SAMHSA, 2008).

Misuse of opiates, especially prescription pain medications, appears to be an important factor driving the increase. The SAMHSA report "Older Adults in Substance Abuse Treatment: Update" noted that the percentage of older adults with opiates as their primary substance of abuse increased during the past five years. Although alcohol is still the primary substance of abuse among older adults, the proportion of hospital admissions for alcohol-related medical problems declined from 86.5% in 1995 to 77.5% in 2002 (Moran, 2005; NSDUH, 2010). However, other drug admissions, especially among older women age 55 and older, during the same period increased (Moran, 2005).

To counter the upward trend in the abuse of opiates, SAMHSA is sponsoring new advertisements in print and visual media called "Do the Right Dose" when using prescription pain relievers. Though the results of this campaign are in the beginning stages, the outcome seems hopeful as the general population is better informed and health care professionals and family members become more vigilant in their monitoring of older adults.

As social workers involved in the evaluation and subsequent treatment of persons with substance use disorders, it is ethically incumbent for each

of us to have a thorough and replete understanding of the dynamics involved in serving an aging population. We can no longer simply assume this population is not at an inherent risk. Finally, as clinical social workers involved in family assessments, we have to strive to gain a better understanding of the at-risk potential of older family members who may have an addiction problem that has not been addressed and may be extremely well hidden.

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References

Gfroerer, J., Penne, M., Pemberton, M., & Folsom, R. (2002). Substance abuse treatment need among older adults in 2020: The impact of the aging baby-boom cohort." *Drug and Alcohol Dependence, 69*, 127-135.

Moran, M. (2005). *Psychiatric News. (40)*12. Washington, DC: American Psychiatric Association.

National Survey on Drug Use and Health (NSDUH). (2010). Washington, DC: Government Printing Office.

Substance Abuse and Mental Health Services Administration (SAMHSA). (2008). Rockville, MD: DHHS Publications.

CLINICAL INTERVENTIONS FOR SERVICE MEMBERS EXPERIENCING PTSD AND SUBSTANCE ABUSE

Michael McCarthy, MSW

Eight years of combat in Iraq and Afghanistan have increased the visibility of the mental health needs of returning service members and the services that are available to them. Much of this focus has been on service members with post traumatic stress disorder (PTSD). However, recent research has documented the complex interaction between PTSD and a number of social, demographic, and behavioral considerations. One of the most important of these considerations is the relationship between alcohol abuse and PTSD. In a comprehensive literature review, PTSD was found to be predictive of alcohol abuse, while alcohol abuse exacerbated PTSD symptoms (Jacobsen, Southwick, & Kosten, 2001).

Military demographics include an over-representation of males between the ages of 18 and 25, suggesting that alcohol abuse has the potential to be a significant military public health concern. The concern produced by a demographic propensity for elevated levels of alcohol abuse is amplified by high rates of combat exposure. Maladaptive alcohol use may increase anxiety/arousal states, making it more likely that individuals with substance use disorders will develop PTSD after trauma exposure (Jacobsen et al., 2001). Likewise, PTSD could increase the risk of developing a substance use disorder because individuals may abuse substances in an attempt to relieve symptoms of PTSD. Substance use may also exacerbate symptoms or prolong the course of PTSD by preventing habituation to traumatic memories (Brady & Sinha, 2005). In fact, 64% - 84% of veterans with PTSD met the criteria for lifetime alcohol abuse disorder (Brady & Sinha, 2005). Recent research suggests that military members are at elevated risk for developing an alcohol-related disorder following a traumatic deployment. For 57.5% of those with both a substance use disorder and PTSD, their most traumatic event occurred before the onset of substance use disorder symptoms (Mills, Teesson, Ross, & Peters, 2006). Both PTSD and alcohol abuse can have debilitating consequences. The co-morbidity of these conditions produces a negative synergistic effect.

As a result of the Gulf War syndrome, military medical and public health officials have taken a more holistic approach to public health and post-deployment issues. All military members who are sent to a combat zone complete a comprehensive battery of assessments within two weeks of their return and again at 90-120 days after their return (Hoge, Auchterlonie, & Milliken, 2006). In addition to screening for trauma-related conditions, returning combatants complete an alcohol assessment, including the Alcohol Use Disorders Identification Test (AUDIT-C). This assessment is triaged by a medical professional, and at-risk individuals are referred to appropriate specialty providers.

While screening and treatment are vital components of an effective response to the medical and emotional needs of military members, increased focus is being spent on prevention approaches. The Culture of Responsible Choices (CoRC) program instituted by the Air Force is an example of this trend. CoRC evolved out of the stunningly successful 0-0-1-3 pilot project developed in 2004 at F.E. Warren Air Force Base in Wyoming in response to rampant incidents of binge drinking among college students. Based on social norms theory, the 0-0-1-3 program was initiated, institution-wide, at F.E. Warren to instruct airmen in socially acceptable alcohol use, with its title reflecting the program goals. The first zero communicated to airmen that underage drinking is not accepted within the Air Force culture. Zero drinks if you are under 21. The second zero reinforced the cultural norms regarding drinking and driving.

Zero drinks if you are driving. The one and the three prescribed appropriate alcohol consumption—one drink per hour, three drinks per occasion. Airmen at F.E. Warren were expected to follow the program or risk their careers, as well as risk their lives or the lives of others while driving intoxicated. Research has found that targeting social norms regarding alcohol misuse may reduce binge drinking and amount of consumption (Moreira, Smith, & Foxcroft, 2009). This was the case at F.E. Warren. There were significant reductions in all categories of alcohol-related incidents after the 0-0-1-3 program was implemented.

In recent years, the CoRC program has been executed Air Force-wide. CoRC has expanded beyond its roots in alcohol prevention to a holistic, community wellness approach. Suicide prevention and the de-stigmatization of help-seeking behaviors and mental health care are central to the CoRC program. The Air Force uses innovative multimedia platforms to engage mental health issues at the community level. Research suggests that adjusting attitudes about alcohol use and mental health issues among 18- to 25-year-olds is most effectively accomplished in a multimedia format (Moreira et al., 2009).

Short-term projections indicate that American service members will continue to be exposed to active combat. The rapid recycling tempo of operations taxes the resilience and social support of military members (Hoge et al., 2006). This creates an increased vulnerability for emotional dysfunction and maladaptive coping strategies such as substance abuse. Because studies on the emotional effects of these demands are just beginning to be published, the efficacy of present treatment and prevention approaches is still inconclusive.

The social work profession will serve a vital role in meeting the needs of reintegrating service members and in critiquing the systems from which they receive support. Social workers must understand the complex interaction between PTSD and alcohol misuse in order to provide competent, evidence-based interventions to meet the future needs of veterans.

Michael McCarthy, MSW, is a doctoral student at the University of Texas at Austin and currently serves in the U.S. Air Force.

Resources

The complete alcohol assessment, including the AUDIT-C, is available in PDF format for downloading at www.dtic.mil/whs/directives/infomgt/forms/forminfo/forminfopage3291.html.

For more information on the CoRC program, visit the Air Force Crossroads Web site at www.afcrossroads.com/websites/corc.cfm.

References

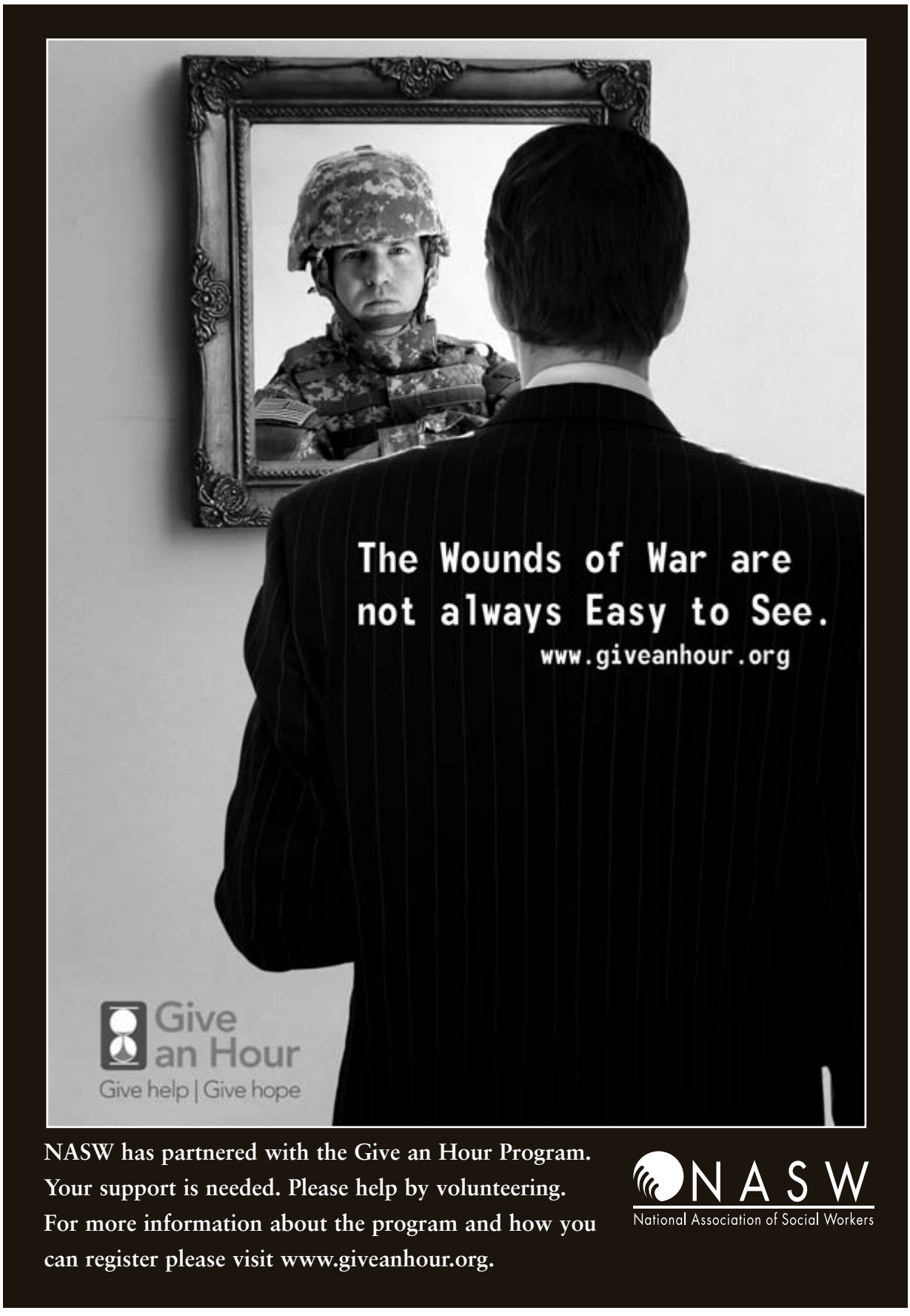
Brady, K.T., & Sinha, R. (2005). Co-occurring mental and substance use disorders: The neurobiological effects of chronic stress. *American Journal of Psychiatry, 162*(8), 1483-1493.

Hoge, C.W., Auchterlonie, J.L., & Milliken, C.S. (2006). Mental health problems, use of mental health services, and attrition from military service after returning from deployment to Iraq or Afghanistan. *Journal of the American Medical Association, 295*(9), 1023-1032.

Jacobsen, L.K., Southwick, S.M., & Kosten, T.R. (2001). Substance use disorders in patients with posttraumatic stress disorder: A review of the literature. *American Journal of Psychiatry, 158*(8), 1184-1190.

Mills, K.L., Teesson, M., Ross, J., & Peters, L. (2006). Trauma, PTSD, and substance use disorders: Findings from the Australian national survey of mental health and well-being. *American Journal of Psychiatry, 163*(4), 652-658.

Moreira, M.T., Smith, L.A., & Foxcroft, D. (2009). Social norms interventions to reduce alcohol misuse in university or college students. *Cochrane Database of Systematic Reviews: Reviews 2009*(3).



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