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DRUG ALCOHOL ABUSE AMONG THE ELDERLY IN NYC

Jan 24, 1995
The Council of the city of New York

Subcommittee on Mental Health

Date: 1/24/95

Int. Res. 197 M-

Oversight Subject: Drug + Alcohol Abuse
Among the elderly in N.Y.

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Total Present

Other Council Members Attending: Smith, Crane, Harrison, Lasher, Lincoln, Pearson, McCabe, White, Pinkett

Time of Opening: 10:05

Time of Adjournment: 1:05

Speakers: All40
LIST OF WITNESSES

Ernest Batson, Associate Commissioner of the Bureau of Alcoholism and Substance Abuse Services for the Department of Mental Health, Mental Retardation and Alcoholism Services

Michael Rabin, Deputy Commissioner of the Department for the Aging

FIRST PANEL

Dorothy D., member of Alcoholics Anonymous

Thomas Swan

SECOND PANEL

Representative of Hunts Point Multi-Service Center Program servicing older alcohol and substance abusers

Representative of Coney Island Hospital servicing older alcohol and substance abusers

Dr. Sheldon Zimberg, a geriatric and addiction psychiatrist

Dr. Joanna Mellor of the Brookdale Center on Aging at Hunter College
The Council

Report of the Division of Human Services

Oliver Gray, Director

Committee on Aging

Council Member Julia Harrison, Chair

Jointly with

Subcommittee on Mental Health, Mental Retardation, Alcoholism and Drug Abuse Services

Council Member Una Clarke, Chair

Res. No. 197:

By: Council Members Povman and White; also Council Members Cruz, Foster, Harrison, Koslowitz, Lasher, Leffler, O'Donovan and Williams

Subject:

Resolution calling upon the appropriate committee of the Council to hold hearings on the problem of drug and alcohol abuse among the elderly population in New York City.

On Tuesday, January 24, 1995, the Committee on Aging, chaired by Council Member Julia Harrison, will hold a joint hearing with
the Subcommittee on Mental Health, Mental Retardation, Alcoholism & Drug Abuse Services, chaired by Council Member Una Clarke, on drug and alcohol abuse among the elderly. Representatives from the Department of Mental Health, Mental Retardation and Alcoholism Services (DMH) and the Department for the Aging (DFTA) are expected to testify. In addition, the following witnesses are expected to testify in panel format: Dorothy D., a member of Alcoholics Anonymous (AA), who is expected to discuss the work of AA with seniors, and Thomas Swan, who is studying aspects of alcoholism through a foundation grant (first panel); Dr. Joanna Mellor of the Brookdale Center on Aging at Hunter College, Dr. Sheldon Zimberg, who practices geriatric and addiction psychiatry, and a representative from a service program which treats elderly drug and alcohol abusers (second panel).

BACKGROUND:

While substance abuse among younger people is a widely recognized problem in New York City, alcohol and drug abuse among the elderly is under-recognized and under-reported. The problem of abuse is nevertheless widespread among the elderly. Between 1.1 million and 2.3 million older Americans have problems with alcohol. Estimates are that hospital admissions of the elderly for alcohol-related problems outnumber admissions for heart attacks. While opiate and cocaine abuse is comparatively rare among the elderly, abuse and misuse of prescription and over-the-counter drugs is commonplace. More prescription drugs are dispensed and used by seniors than by any other age group; the elderly population is at
high risk for prescription drug abuse. The New York State Office of Alcoholism and Substance Abuse Services has recently estimated that half of the medications used by seniors interact negatively with alcohol, strengthening, weakening or totally negating the effects of some medications, or in some cases, leading to more rapid intoxicification.

EXISTING SERVICES:

To address this serious but under-recognized problem, DHM contracts with agencies that provide both in-patient and out-patient rehabilitation services to the elderly with alcohol, drug and mixed abuse problems. Through its Office of Training and Development, DHM provides training to care giving professionals to better recognize and refer abuse problems of many populations of substance abusers, including the elderly. DFTA provides referral and information services to seniors on alcohol and drug abuse services. In addition, AA, which focuses on alcohol abuse only, provides groups for recovering alcoholics in the New York area. Connection with a peer support group placing a high priority on abstinence, like those sponsored by AA, is cited by many alcoholism experts as the most important element in the recovery process.

IMPEDIMENTS TO DIAGNOSIS AND TREATMENT:

Notwithstanding the activities of DHM and DFTA and existing peer support group organizations, seniors with an abuse problem are very often not diagnosed or treated. Many in the current generation of seniors see the problem of drug and alcohol abuse as cause for shame; abuse professionals note repeatedly that the
elderly are generally unlikely to seek out treatment. Because of the stigma accompanying an abuse problem, seniors and other family members may deny the existence of an alcohol or drug problem to health care professionals. Reluctance to seek treatment is often compounded by the failure of health care professionals who see seniors on a regular basis to recognize common indicators of alcohol or drug abuse in elderly patients which may be quite different from signs of a problem in younger patients. For instance, because many of the elderly do not work, physical signs of falls or accidents in the home may be a more common indicator of an abuse problem than typical indicators among the young such as job performance problems. Care givers also sometimes mistake symptoms of drug and alcohol abuse for dementia or other conditions often associated with aging. With respect to drug abuse, professionals are often unaware of the multiple prescriptions or over-the-counter drugs an elderly patient is using and therefore do not assess the risk of an additional prescription. In the case of alcohol abuse, the commonplace belief of family, friends, neighbors or health care professionals that drinking is one of the "few joys" remaining to the elderly is an additional barrier to treatment. This view ignores the fact that, far from adding to the quality of a senior's life, a strong statistical link has been shown to exist between elderly substance abuse and suicide.

SOCIAL COSTS:

The social and economic costs of failing to diagnose and treat
alcohol and drug abusing seniors are high. Estimates are that 15% to 23% of senior problem drinkers attempt suicide; in contrast to attempts by younger individuals, it is rare that a suicide attempt by a senior does not result in death. Abuse has been cited by gerontologists as an important reason why the elderly have the highest rate of suicide of any age group.

While additional research needs to be done for accurate estimates of direct and indirect health care costs attributable to drug abuse and alcoholism among the elderly, estimates are that the cost of hospitalization of the elderly for alcohol-related reasons alone was approximately $60 billion nationwide in 1990; other studies have shown that between 9% and 20% of all the hospitalized elderly are heavy alcohol users. National studies have also shown that each year several hundred thousand seniors are hospitalized for adverse effects to prescription and over-the-counter drugs.

RECOVERY MECHANISMS:

Concerned professionals have suggested that an efficient means of improving diagnosis and referral is through increasing training of care givers who already are in contact with and have the confidence of elderly patients and clients outside the context of substance abuse. This is especially so with the elderly because of their well-established hesitancy to seek help from an unfamiliar source for a stigmatized problem. Also, in the view of some senior substance abuse experts, because some older alcoholics are often less in need of detoxification services than group therapies,
increased referral to low-cost, peer group programs would help many seniors, although views differ as to whether individual peer groups should be comprised of elderly people only or mixed generations.
Resolution calling upon the appropriate committee of the Council to hold hearings on the problem of drug and alcohol abuse among the elderly population in New York City.

By Council Members Povman and White; also Council Members Cruz, Foster, Harrison, Knalovitz, Lasher, Leffler, O'Donovan and Williams

WHEREAS, Many are aware that substance abuse exists among the youth of our nation, but are unaware that such abuse also exists among the elderly; and

WHEREAS, Physicians have reported an increase in drug and alcohol abuse among the elderly, which is supported by statistics that show senior citizens use 23 percent of the country's prescription drugs and that 40 percent of our nation's senior citizens use over-the-counter drugs on a daily basis, 80 percent of whom also use alcohol, prescription drugs or both; and

WHEREAS, Approximately sixty percent of all elderly men admitted to acute medical wards are active alcoholics and approximately 23 to 44 percent of all elderly patients admitted to acute psychiatric screening wards are drinking to excess at the time of admission; and

WHEREAS, These figures are alarming as senior citizens constitute only 10 percent of our nation's population; and

WHEREAS, It is likely that drug and alcohol abuse will worsen among the elderly as long as they continue to depend upon prescription medication, over-the-counter medication and alcohol to relieve their symptoms of pain, insomnia and stress; and

WHEREAS, There are approximately 1.3 million elderly people living in New York City, many of whom may need help dealing with drug and alcohol addiction; and

WHEREAS, Help for elderly drug and alcohol abusers would be made more available if more people became aware of the prevalence of these problems thereby improving diagnosis and reporting of cases, enlarging inpatient facilities, increasing outpatient service care, including family therapy and improving communication among treatment personnel and organizations such as Alcoholics Anonymous; now, therefore, be it

RESOLVED, That the appropriate committee of the Council of the city of New York hold hearings on the problem of drug and alcohol abuse among the elderly population in New York City.

Referred to the Committee on Aging.
QUESTIONS

January 24 Hearing: Alcohol and Drug Abuse among Seniors

Department of Mental Health, Mental Retardation and Alcoholism Services

1. How many programs does DMH contract with, citywide, that provide alcoholism and drug abuse services to the elderly population, and what is the breakdown of services by borough?

2. What services do these programs provide?

3. How many of these programs provide service dedicated only to the elderly?

4. How does DMH and its contracting agencies reach out to seniors to inform them of programs available to them?

5. How does DMH coordinate services and/or outreach activities with other concerned agencies and organizations such as DFTA, individual senior centers and Alcoholics Anonymous?

6. DMH's Office of Training and Development provides training to health professionals so they can better recognize and refer abuse problems among the elderly.

How specific is this training to abuse among the elderly? Which professionals receive this training? Are professionals who see the elderly for general care not related to abuse trained?

DEPARTMENT FOR THE AGING

1. Since seniors may be in contact with DFTA's senior centers and contracting agencies more frequently than with DMH organizations, what does DFTA do to refer seniors to DMH? To other organizations that may help, such as Alcoholics Anonymous? Is referral information available on an anonymous basis?

2. How would an elderly person attending a senior center learn about the availability of alcoholism or drug abuse services for the elderly?

3. Some professionals have suggested that peer support groups for elderly alcohol and drug abusers might be held in senior centers. What is your reaction to this suggestion?

FIRST PANEL

Questions for Alcoholics Anonymous Representative:

1. We know that AA sometimes holds meetings for special
populations of people with alcohol problems. Does AA hold special meetings for the elderly or are younger and older people present at the same meeting? Some believe this has an impact on the success of recovery. Is this AA's experience?

2. Does AA receive referrals from city agencies? Is there ongoing communication with DMH or DFTA?

Question for Thomas Swan:

Having been through stages of recovery yourself, what needs improvement in the area of diagnosis? In the area of treatment?

SECOND PANEL

Questions for Service Providers:

1. What is a typical profile for an elderly person you treat?

2. Where do you get your patients? What kind of outreach do you do? Do you have to turn people away because of lack of resources?

3. What can DMH do to better to coordinate services?

4. Does your program include peer support groups? How are these different, if at all, from the kinds of groups AA arranges? Are groups comprised of only the elderly or are they intergenerational?

Questions for Dr. Zimberg:

In your testimony, you have noted a peer group treatment approach. How is this different from the groups AA sponsors? How is it different from what is offered by the service providers who spoke earlier? Is there a higher success rate? Is such treatment cost-effective?

Questions for Dr. Mellor:

You have stressed the importance of education in your testimony. In your experience, what improvements in diagnosis and treatment occur after education of health care professionals?
Opening Statement

Council Member Julia Harrison, Chair
Committee on Aging

Alcohol and Drug Abuse by the Elderly

January 24, 1995 -- 10 a.m.

Good morning. Today, the Committee on Aging will hold a hearing jointly with the Subcommittee on Mental Health, Mental Retardation, Alcoholism and Drug Abuse Services on the subject of drug and alcohol abuse among the elderly.

While substance abuse among younger people is a widely recognized problem in New York City, alcohol and drug abuse among the elderly is under-recognized and under-reported. The problem of abuse is nevertheless widespread among the elderly. Estimates are that hospital admissions of the elderly for alcohol-related problems alone outnumber admissions for heart attacks; between 1.1 and 2.3 million older Americans have problems with alcohol. While opiate and cocaine abuse is comparatively rare among the elderly, abuse of prescription and over-the-counter drugs is commonplace. More prescription drugs are dispensed and used by seniors than by any other age group; the New York State Office of Alcoholism and Substance Abuse Services has recently estimated that half of the medications used by seniors interact negatively with alcohol.

Despite existing services for the elderly, seniors with abuse problems are very often not diagnosed or treated. There are many reasons why seniors do not get help, ranging from shame and reluctance on the part of the elderly in seeking treatment to
inadequate experience on the part of many professionals in diagnosis of a problem. It is clear, however, that the human and economic costs of leaving many seniors undiagnosed and untreated are too high. For this reason, the Committee plans to discuss mechanisms for ensuring seniors with abuse problems more often receive treatment.

Before I turn to Council Member Clarke, who will say a few words by way of introduction, I would like to note that one of our witnesses today who will appear later, Dorothy D., is a member of Alcoholics Anonymous here on condition of anonymity. I ask that any members of the press present not photograph or identify her any further than she will herself in her testimony.
CITY COUNCIL PUBLIC HEARING

on Resolution No. 197

DRUG AND ALCOHOL ABUSE

AMONG THE ELDERLY

in

NEW YORK CITY

ERNEST E. BATSON

ASSOCIATE COMMISSIONER

Testimony submitted

on

Tuesday, January 24, 1995

at

City Council Hearing Room

250 Broadway, 23rd floor

New York, New York 10007
I. INTRODUCTION

Good morning. I am Ernest E. Batson, Associate Commissioner of the Bureau of Alcoholism and Substance Abuse Services for the Department of Mental Health, Mental Retardation and Alcoholism Services (DMH). I am pleased to present testimony on behalf of the Department's Commissioner, Dr. Luis R. Marcos.

II. BACKGROUND ON DEPARTMENT OF MENTAL HEALTH

The Department in contract with 200 agencies serves over 310,000 clients annually. Among the clients served in these programs are mentally ill individuals, persons addicted to alcohol and other drugs, children and adolescents, older persons, persons with AIDS or infected with the HIV virus and many homeless persons.

III. BUREAU OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES

The Bureau of Alcoholism and Substance Abuse Services is responsible for the planning, contracting, monitoring and evaluation of all alcoholism services. In March of 1994, Mayor Rudolph Guiliani designated the Department of Mental Health as the lead agency for planning substance abuse services in the City of New York. However, New York State Office of Alcoholism and Substance Abuse Services, (OASAS) continues to be responsible for contracting and monitoring the approximately 400 substance abuse programs in the City.
The alcoholism and substance abuse provider system serves many at-risk populations. These include polysubstance abusers, mentally ill chemical abusers, youth, the elderly, women of child bearing age and the developmentally disabled.

Today, I would like to address a topic that the Committee on Aging and Subcommittee on Mental Health, Mental Retardation, Alcoholism and Drug Abuse has identified: the problem of Alcohol and Drug Abuse Among the Elderly. The Council's resolution No. 197 captures the essence and magnitude of the problem. The Committee clearly articulates the scope of its impact on the elderly, so many of whom are affected by substance abuse.

According to the 1990 U.S. Census Bureau figures, there are approximately 31,241,831 persons aged 65 and over in the United States. 3,188,832 live in New York State and approximately 1.3 million in New York City. It is estimated that between 78,000 to 156,000 which is 6% to 12% of this population, have problems with alcohol, in combination with prescription and over the counter medications.

According to The New York City Department for the Aging, in 1980 there were a total of 1,296,965 persons over age 60 in New York City. In 1990, the number was 1,278,105 a negative difference of 18,860. On a Citywide basis, there are approximately 187,066 persons over age 60 in the Bronx, 382,307 in Brooklyn, 264,789 in Manhattan, 385,772 in Queens and 58,171 in Staten Island.
For the purpose of definition, elderly will be described as age 60 and older, although it is recognized that in terms of substance abuse, there are a number of persons age 50 to 60 who are chronically debilitated, homeless and disaffiliated, and who do not have adequate insurance coverage as a result of their abuse of alcohol and other substances.

In providing substance abuse services to the elderly, we must recognize the diversity of this population, and the many issues they face. Among these issues are:

- Access to Treatment
- Home Health Care
- Lack of Transportation
- Respite Care
- Limited Financial Resources
- Housing
- Loss of spouse and significant others
- Need for a Caretaker
- Homebound
- Elder Abuse
- Domestic Violence
- Lack of Insurance Coverage
- Rising Costs of Treatment
While it is agreed that the elderly face the struggle of physical, psychological and social trauma, such as debilitating or failing health, the normal aging process, isolation, boredom, stress and at times despair, we must recognize their resiliency and strength. The elderly bring with them a lifetime of experiences that can contribute to the development of a better quality of life.

There are increasing numbers of older persons who are abusing alcohol and other drugs in combination with prescription and over the counter medications who are not receiving intervention and treatment. Many are being misdiagnosed. There is a belief by the general population that the elderly have already lived their lives and should be left alone. Some of the barriers to substance abuse treatment for older persons range from the phenomena of denial that the problem exists, to the perception that the older substance abuser will not benefit from treatment.

Alcoholism and other substance abuse among the elderly is increasing because the numbers of older persons are growing, individuals are living longer, retiring earlier without adequate preparation for leisure activities, and their physical tolerance to alcohol and other substances is reduced. In conjunction with the use of medications, alcohol and other drug use can affect older persons already facing declining health in the normal aging process.
IV. HISTORICAL BACKGROUND OF INTERAGENCY COUNCIL ESTABLISHED BY (DMH) & DEPARTMENT FOR THE AGING (DFTA)

In the Fall of 1988, the Department's Bureau of Alcoholism Services in conjunction with the Department for the Aging, established a Committee on Alcoholism and the Elderly. Twenty five members from both the aging network and the alcoholism service system began the arduous task of cross education, of addressing barriers and biases, turf issues, stigma and linkage of older persons to alcoholism referral and treatment. The council members have identified and addressed issues related to successful delivery of geriatric care and Alcohol and Substance Abuse Services to New York City residents.

Throughout the past six and a half years, the Committee, now known as the "NYC Interagency Council on Older Persons, Alcohol and Other Substances" has been successful in reaching out to, educating and treating the elderly through cooperative efforts of both the senior care network and alcoholism and other substance abuse providers. Since its inception, the focus has been on developing an integrated approach to serving older persons whose lives are adversely affected by alcoholism and other substance abuse problems.

Collaboratively, we have accomplished the following:

- Identified older persons with an alcohol/substance abuse problem.
- Increased referrals of older persons to substance abuse programs.
- Increased the awareness of providers in both the senior care and
substance abuse systems of the special needs of the elderly.

The Interagency Council meets every five to six weeks from September through June. The Council also sponsors an annual conference. Participants are from the senior care system, and the alcoholism and other substance abuse system. Our fifth conference is being planned for June 14, 1995. The last conference held on April 22, 1993 was attended by more than 350 participants.

The council members are also currently working on the development of a resource manual, a provider directory, a public service campaign and a poster design that will focus on older persons who abuse alcohol and other substances and/or who are alcoholic.

The incidence and prevalence of alcohol and other drug use, misuse, abuse and addiction among the elderly emphasize the need for education about the problem among the general public, medical professionals and to all systems with a coordinated agenda.

There is a need for more aggressive outreach, prevention, the development of a special care inpatient model for elderly persons, an expansion of existing services and the establishment of new service providers. Furthermore, it is essential to establish linkages between self help and fellowship organizations which have demonstrated that abstinence and recovery are possible, that treatment works, that prevention and intervention strategies to reduce alcohol and other substance abuse among the elderly are vital to
their well being. Resolution No. 197 highlights many of these issues.

In order to be responsive to the needs of the elderly, we must be sensitive to the concern of the aging process as well as to the issues of Alcohol and Substance Abuse. Given these intricate issues, programs designed to provide services to special needs populations must be implemented.

It has been demonstrated in existing programs that substance abuse services for the elderly can be successful and that this population is treatable. Most of the programs providing the services, however, do not receive specific funding to operate and staff special service components. Many have developed specialized service tracks initiated by interested staff members who are committed to working with older persons.

Alcohol and substance abuse among the elderly is significant, the seriousness of which is complicated by isolation, family breakdown, lack of transportation, failing health and mental health, social and spiritual issues. During these times, the need for substance abuse services for the elderly is vital. These services will provide the elderly with alternatives to addiction, access to treatment and outreach which will result in enhanced opportunities to live longer, healthier and more productive lives.

RECOMMENDATIONS

The Department of Mental Health, Mental Retardation, Alcoholism and Substance Abuse Services will take the initiative to accomplish the following:

- Develop an alcohol and substance abuse awareness/training plan with the
Department for the Aging to include:

- Visits to senior centers and borough wide events;
- Work with the Pharmaceutical Association to disseminate alcohol and substance abuse education material to their elderly clients;
- Disseminate alcohol and substance abuse education material to Senior/Special Citizens Committees of the 59 Community Boards in New York City;
- Provide the Department for the Aging with packets of alcohol and substance abuse resource materials and program directories for distribution to their programs;
- Work with the Department of Consumer Affairs for distribution of alcohol and substance abuse education material to the businesses that serve the elderly;
- Work with the New York City Department for the Aging for distribution of alcohol and substance abuse material to all seniors that participate in the Senior Citizen Rent Increase Exemption Program (SCRIE);
- Expand the membership of the NYC Interagency Council on Older Persons, Alcohol and Other Substances to include other City agencies that provide services to the elderly.

I THANK YOU.
FACT SHEET

EXISTING ALCOHOLISM AND SUBSTANCE ABUSE SERVICES FOR OLDER PERSONS

Bronx Lebanon Hospital Center
321 East Tremont Avenue
Bronx, NY 10454
(718) 518-3700 - Alfredo Garcia
Provide service to African American and Latinos, most of whom are homeless males, age range 46 to 80.

Hunts Point Multi - Service Center Program, Inc.
630 Jackson Avenue, 2nd fl.
Bronx, NY 10455
(718) 993-3010 - Maria Garcia
Provide services to Latinos males aged 45 to 70. Increase in services to women aged 55 to 79.

Our Lady of Mercy Medical Center
4401 Bronx Boulevard
Bronx, NY 10470
(718) 920-9100 - Lorraine Rivers
Provide services to male and female "seniors" age 50 to 85.

Soundview Throgs Neck CMHC
1957 Turnbull Avenue
Bronx, NY 10474
(718) 597-3888 - Lois Smith
Provide services to African American and Latino(a) men and women aged 65 to 84.

Coney Island Hospital
Building #2
2106 Ocean Parkway
Brooklyn, NY 11235
718- 615-5972 - Kevin Siewers
Provide services to men and women aged 62 to 80.

St. Lukes/Roosevelt Hospital
324 West 108th Street
New York, NY 10025
212-678-6311 - Pat Murphy
Provide services to homeless alcoholic and other substance abusers aged 50 to 85.
EXISTING ALCOHOLISM AND SUBSTANCE ABUSE SERVICES FOR OLDER PERSONS

Episcopal Health Services, Inc. St. John’s Episcopal Hospital
1815 Cornaga Avenue
Far Rockaway, NY 11691
718-327-2077 - Joe Molnar
Provide comprehensive services to males and females aged 60 to 80.

St. Vincent's Medical Center, North Richmond CMHC
Bayley Seton Hospital, Bldg,#2, 2nd fl.
Bay Street, & Vanderbilt Avenue
Staten Island, NY 10304
718-876-1227 - John Cella
Provide services to men and women aged 65 to 80.

Beth Israel Medical Center
Methadone Maintenance Treatment Program
Queens Clinic Outpatient Department
82-68 164th Street - Building "J"
Queens, New York 11432

(718) 883-4084 Fred Bailey
Outpatient methadone maintenance services provided to men and women ages 50 to 80.

J-CAP
Queens Village Committee for Mental Health
156-02 Liberty Avenue
Queens, New York 11433

(718) 380-4126 Mr. Shepherd
Services provided for men and women ages 50 to 60.

Long Island Jewish Medical Center
Methadone Maintenance Treatment Program
276-05 76th Avenue
Queens, New York 11042
(718) 470-8940 Richard Waytek
Provide services to men and women ages 50 to 63.
FACT SHEET Continued

EXISTING ALCOHOLISM AND SUBSTANCE ABUSE SERVICES FOR OLDER PERSONS

Mary Immaculate Hospital
Methadone Maintenance Treatment Program, Unit 2
147-20 Archer Avenue
Queens, New York 11432

(718) 291-8888 Intake (Rotating)

Provide services to men and women ages 50 to 65.

Queens Hospital Center
Inpatient Detoxification Center
82-68 164th Street
Queens, New York 10432

(718) 883-4273 Edward Reardon

Provide services to persons age 50 to 64.

Queens Hospital Center
Accupuncture Center
82-68 164th Street
Queens, New York 11432

(718) 883-4706 Richard Smith

Samaritan Village, Inc. ETY
88-83 Van Wyck Expressway
Queens, New York 11435

(718) 657-6195 Arnie Razumny

Provide services to men and women ages 50 to

OUTREACH AND REFERRAL

Alcoholism Council Fellowship Center of New York
49 East 21st Street
New York, NY 10010
212-979-6277 - June Lazerus
Services to all age groups
Most Americans, perhaps as many as seventy-three percent of the adult population, use alcohol. The vast majority of drinkers use alcohol in a non-hazardous, non-harmful manner. Although estimates vary as to the exact numbers, there may be as many as 19 million drinkers for whom alcohol use has resulted in problems. Of these, about 8 million show signs of physical tolerance, loss of control, and are classified as alcohol dependent (alcoholic) under current diagnostic criteria. The remaining 11 million drinkers have experienced a variety of alcohol-related problems, but are not alcohol dependent.

These non-dependent drinkers fall into two broad categories. Hazardous drinkers are those whose drinking has resulted in some negative consequences (e.g., DWI arrests, family or work problems), and who are at risk to develop some significant physical and psychological consequences as a result of their drinking. Harmful drinkers are those who have begun to experience health-related consequences of drinking that are either physical (e.g., alcohol-related injuries or medical problems), psychosocial (e.g., disturbances of mood or social functioning), or both. Although neither hazardous nor harmful drinkers are alcohol dependent, alcohol is, from time to time, a source of significant difficulties for them.

Most intervention and treatment programs focus on providing help to persons who are already alcohol dependent (e.g., alcoholic). Treatment programs have typically ignored hazardous and harmful drinkers for whom early intervention may prevent exacerbation of alcohol-related problems and avert progression to alcohol dependence.

Because hazardous and harmful drinkers have suffered only a few of the many negative consequences associated with alcohol use, they often do not seek treatment or help with drinking, yet they utilize health care and legal system resources at a rate that is disproportionate to that of others their age. Identification of and early intervention with these drinkers are significant means of reducing the harm their drinking may cause to both themselves and others. Screening of drinkers in health care settings through use of such simple measures as the CAGE questions, with the addition of a question about smoking for women to form the CAGE-S (see Figure), can identify many hazardous and harmful drinkers before they become alcohol-dependent and can set the stage for early intervention with this large group of drinkers.

THE CAGE-S QUESTIONNAIRE

1. Have you ever felt that you should cut down on your drinking?  
2. Have people ever annoyed you by criticizing your drinking?  
3. Have you ever felt bad or guilty about your drinking?  
4. Have you ever had a drink first thing in the morning to steady your hands or get rid of a hangover (eye-opener)?  
5. (For Women Only) Do you smoke cigarettes?


Interventions with hazardous and harmful drinkers need not be lengthy or expensive. There are a number of clinical research groups both in the US and abroad that have studied a variety of brief interventions with these drinkers, with highly encouraging results. Many studies have found that brief interventions of only one or two sessions can produce changes in drinking behavior that are as great and long-lasting as those produced by more extensive, and expensive, counseling (see Bien, Miller & Tonigan, in press, for a review of this research). In studies of more than 6,000 clients worldwide, brief interventions have demonstrated their efficacy with non-dependent problem drinkers.

What constitutes a brief intervention? Brief interventions range from distribution of a self-help manual upon response to a newspaper ad, with no therapist or counselor contact, to simple advice given by a physician in the office, to more complex interventions that focus on teaching drinkers self-control skills. The number of sessions used has ranged from zero to five with an average of two sessions being the norm.

There are several characteristics of brief interventions that appear to contribute to their effectiveness. The first is provision of objective, normative, feedback about how one's drinking compares with that of others and about the current consequences of drinking on the drinker's physical health. Simply drawing a clear link between a drinker's current problems and his/her drinking appears to be sufficient to induce many hazardous/harmful drinkers to reduce drinking or stop altogether.

A second characteristic of brief interventions is an emphasis on active client involvement in selection of his/her drinking goal. Abstinence, though perhaps recommended by the therapist, is not imposed on the client as the only legitimate goal of treatment. Rather, moderate drinking and abstinence are each presented as possible goals that may be appropriate for a particular individual, depending upon the nature of his/her alcohol-related problems. The client is the one who ultimately chooses the goal towards which he/she will work, a situation that appears to increase client motivation and commitment to change. Research has shown that many problem drinkers, even ones who attend abstinence-oriented treatment programs, become moderate drinkers, while many drinkers who initially reject abstinence as a goal, eventually become abstinent.

The third characteristic of many brief interventions is a focus on teaching drinkers specific skills to track and change their drinking behavior. The specific skills that are taught depend on a thorough assessment of the client's drinking behavior, including quantities consumed and the frequency of drinking, the time frame of the client's typical drinking episode, rate of drinking, the consequences of drinking, and specific situations in which the client is more likely to drink to excess. Clients are then taught skills that are tailored to their own particular drinking goals and pattern.
An example of a brief intervention program that contains all of these components is the Drinker's Check-up/Behavioral Self-control Training Program developed by William R. Miller and his colleagues at the University of New Mexico. This program has a number of steps through which the client proceeds in as few as four sessions, depending on the severity of the client's drinking problems. These steps include (1) a thorough formal assessment of the client's drinking pattern and drinking-related consequences, including health and neuropsychological status. Blood chemistry analyses and neuropsychological testing are a major component of the assessment. Since even social drinkers have been shown to show drinking-related changes in liver and brain functions, the assessment is followed by (2) formal feedback of the assessment results and determination of the drinking goal to which the client is most willing to commit himself/herself. If data from the assessment indicate that abstinence may be the most appropriate drinking goal, but the client chooses to attempt moderated drinking, the therapist will negotiate a contract with the client at the end of which, if moderation has failed, the client agrees to shift to an abstinence goal. The purpose of this contract procedure is to enhance the client's personal commitment to the drinking goal being sought, and thereby to increase the chances for successful treatment outcome.

Once a drinking goal has been established, the next step is to (3) set mutually agreed-upon limits on the number of drinks a client will consume per day and the peak blood alcohol content (BAC); the client will attain in any day. If the client has selected abstinence as a goal, these limits will be set at zero, or are gradually reduced until abstinence is achieved. Next, (4) the client is instructed in the self-monitoring of drinking behaviors and BAC, and (5) taught how to change the rate of drinking by adopting one or more of several specific strategies (switching from stronger to weaker drinks, alternating alcoholic with non-alcoholic drinks, sipping slowly rather than gulping, spacing drinks out over time.) At the same time clients (6) receive instruction on, and practice, drink refusal skills, and (7) are shown how to set up a personal reward system for reinforcing goal achievements. The final components of the program focus on (8) teaching clients to recognize antecedents of excessive drinking (e.g., being with a particular group of friends or in a particular drinking setting), and to develop other coping skills to use instead of drinking.

Brief interventions similar to Miller's hold great promise for reducing the occurrence of alcohol-related problems on a wide scale. By implementing early, cost-effective brief interventions with problem drinkers before they have become alcohol dependent, savings of millions of dollars will be realized—dollars that are now used to provide treatment for persons whose drinking has progressed to alcohol dependence, treatment for alcohol-related medical problems, implementation of legal sanctions for alcohol-related offenses such as DWI, and which are lost through alcohol-related problems in the workplace.

References


The New Jersey Alcohol/Drug Resource Center and Clearinghouse serves institutions of higher education, state agencies, communities, and school districts throughout the state of New Jersey by providing technical assistance, training, and resources in alcohol and other drug abuse education and prevention. For information on the Clearinghouse, call or write to:

NJ Alcohol/Drug Resource Center & Clearinghouse
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Alcohol is a clear, thin, odorless liquid that boils at 173 degrees F (78 degrees C). It can burn and can also mix with water in any proportion. Most types of alcohol, such as amyl, butyl, isopropyl and methyl alcohols, ethylene glycol, and glycerol have many industrial and chemical uses. Ethyl alcohol (ethanol) is one of the few alcohols that man can drink, but it never exists full-strength in any alcoholic beverage. Ethanol or ethyl alcohol is the subject of this fact sheet, and from now on it will be referred to simply as "alcohol."

Alcohol is produced during a natural process called fermentation, which occurs when yeast, a microscopic plant that floats freely in the air, reacts with the sugar in fruit or vegetable juice, creating alcohol and releasing carbon dioxide. The process stops naturally when about 11 to 14% of the juice is alcohol because the amount of alcohol is enough to stop the action of the yeast. A similar process is used to make beer.

Distillation is the process used to make beverages with a higher alcohol content. In this process the liquid is heated until it vaporizes, and then the vapor is cooled until it condenses into a liquid again. Distilled alcoholic beverages (e.g., whiskey, gin, vodka, and rum) contain 40 to 50% alcohol. They are sometimes referred to as "spirits" or "hard liquor."

When someone drinks an alcoholic beverage it flows into the stomach. While it is in the stomach, the drinker does not feel the effects of the alcohol, but alcohol does not remain in the stomach very long. Some of it is absorbed through the walls of the stomach into the bloodstream, but most alcohol passes into the small intestine and then into the bloodstream, and this circulates throughout the body. Once alcohol is in the bloodstream it reaches the brain and the drinker begins to feel the effects of the alcohol. The reason that a larger person does not feel the effects of a drink as quickly as a smaller person is because the larger person has more blood and other body fluids and will not have as high a level of alcohol in the blood after drinking the same amount of alcohol.

The body disposes of alcohol in two ways: elimination and oxidation. Only about 10% of the alcohol in the body leaves by elimination from the lungs and kidneys. About 90% of the alcohol leaves by oxidation. The liver plays a major role in the body’s oxidation of alcohol. When alcohol enters the liver, some of it is changed to a chemical called acetaldehyde. When acetaldehyde is combined with oxygen, acetic acid is formed. When the acetic acid is further combined with oxygen, carbon dioxide and water are formed.

The oxidation of alcohol produces calories. One ounce of pure alcohol contains about 163 calories (or about 105 calories in a 1 1/2 ounce glass of whiskey or gin) but it does not contain vitamins or other physically beneficial nutrients.

The liver can only oxidize a certain amount of alcohol each minute. The oxidation rate of alcohol in a person weighing 150 pounds is about 7 grams of alcohol per hour. This is equivalent to about 3/4 of an ounce of distilled spirits, 2 1/2 ounces of wine, or 7 3/4 or 8 ounces of beer per hour. If a person drank no more than 3/4 of an ounce of whiskey or half a bottle of beer every hour, the alcohol would never accumulate in the body and he or she would feel little of the effects of the alcohol and would not become intoxicated.

Oxidation continues until all the alcohol has left the body. Since the body can only remove a small amount of alcohol at a time, people are advised to drink slowly.

The effects of alcohol on an individual depend on a variety of factors. These include:

How one feels before drinking: If a person is upset and tense, very excited, sad, nervous or even extremely happy, he or she may tend to gulp drinks and actually drink more alcohol than planned.

What the drinker expects alcohol to do: Some people expect a drink to help them feel relaxed, happy, angry or sad. Quite naturally, these feelings can be produced by the drink; how you want to feel helps you feel that way.

How much one drinks: A person who has one drink during dinner is not likely to feel the effects of alcohol. But having six drinks before and during dinner means the individual might not make it through dessert.

CLEANINGHOUSE FACT SHEET, 1990
How long one takes to drink: This is a critical factor: four drinks in one hour will have an obvious effect on the drinker, but the same four drinks over a four-hour period will probably have a very slight, if any, effect.

Type of alcoholic beverage: Some beverages have more alcohol in them than others. Beer has about 4.5% alcohol; "table wines" average from 11 to 14%, "fortified" or "dessert wines" (such as sherry or port) have 16 to 20%, and distilled spirits range from 40 to 60%. However, in normal size, each drink (i.e., 12 ounces of beer, 5 ounces of wine, and 1 1/2 ounces of distilled spirits) contains approximately the same amount of alcohol.

Size of the drinker: Because of the way alcohol circulates in the body, the size of the drinker also relates to the effects of alcohol. A person weighing 220 pounds will not feel the effects of a drink as much as a person weighing 120 pounds.

Food in the stomach: The alcohol does not affect the drinker until it has been absorbed into the bloodstream. Food in the stomach slows the rate of absorption, so that a drink after eating a meal will have less effect than one drunk on an empty stomach.

Experience in using alcoholic beverages: Someone drinking a glass of wine for the first time may feel a light-headedness, but probably not on subsequent occasions. An experienced drinker knows what to expect from alcohol and learns to adjust his reactions to small or moderate amounts.

Alcohol acts directly on the brain and changes its ability to work. The effects of alcohol on the brain are quite complex, but alcohol is usually classified as a depressant. Judgment is the first function of the brain to be affected; the ability to think and make decisions becomes impaired. As more alcohol is consumed, the motor functions of the body are affected.

The effects of alcohol are directly related to the concentration (percentage) of alcohol in the blood. In the following description, the blood alcohol concentrations are those that would probably be found in a person weighing 150 pounds. However, the effects vary among individuals and even in the same individual at different times.

At a blood alcohol concentration of 0.03% (after about one cocktail, one glass of wine, or one bottle of beer) the drinker will feel relaxed and experience a slight feeling of exhilaration. At 0.06% (after two cocktails, two glasses of wine, or two bottles of beer), the drinker will experience a feeling of warmth and mental relaxation; there will be a decrease of fine motor skills and he or she will be less concerned with minor irritations. At 0.09% (after three cocktails, three glasses of wine, or three bottles of beer), reaction time will be slowed, muscle control will poor, speech will be slurred and the legs will feel wobbly. At 0.12% (after four cocktails, four glasses of wine, four bottles of beer), his or her judgment will be clouded, inhibitions are self-restraint lessened and the ability to reason and make logical decisions will be impaired. At 0.15% (after five cocktails, five glasses of wine, or five bottles of beer) vision will be blurring, speech unclear, walking will be unsteady and coordination impaired. 0.18% (after six cocktails, six glasses of wine, or six bottles of beer) all of the drinker’s behavior will be impaired and he or she will find it difficult to stay awake. At a concentration of about 0.30% alcohol in the blood (after 10 to 12 drinks) the drinker will be in a semi-stupor or deep sleep. Most people are not able to stay awake and can blood alcohol concentrations high than 0.30%. If the blood alcohol level reaches 0.50% the drinker is in a coma and in danger of death. As the alcohol level reaches 1% in the blood the breathing center in the brain comes paralyzed and death occurs.

In many states a blood alcohol concentration (BAC) of .10% is considered legal evidence that a driver is intoxicated. Some states use a BAC of 0.08%. In some European countries the legal blood alcohol limit for a driver is as low as 0.05%.

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The content of this fact sheet was taken from "What Is Alcohol and Why Do People Drink?" by Ed. New Brunswick, N.J.: Rutgers Center of Alcohol Studies, 1986.
The New Jersey Division of Mental Health and Hospitals defines mentally ill chemical abusers (MICAs) as persons with diagnoses of severe mental illness and chemical dependence. Specifically, an individual is considered MICA when psychotic and actively abusing alcohol and/or drugs, actively psychiatric with a history of alcohol or drug abuse, and/or actively abusing alcohol or other drugs with a history of severe psychiatric diagnoses. MICAs are most likely to be unemployed young adult males between the ages of 18 and 35. However, persons of other ages and either gender may be MICA.

Persons suffering from concomitant illnesses of psychiatric disability and chemical dependency have been variously referred to throughout the United States as SAMI (Substance Abuse Mentally Ill), Dual Diagnosed, SEICA (Seriously Emotionally Impaired Chemical Abusers), and PICA (Psychiatrically Impaired Chemical Abusers). Whatever term is used to describe persons who are suffering from a dual diagnosis, MICAs present a clear constellation of behaviors, symptoms, and risk factors and require specific treatment technologies.

Psychiatric disability is more common among addicted persons than in the general population. Addiction is more common among psychiatrically disabled persons than among the general population. Both illnesses may be in an acute state simultaneously, or one may be in remission while the other is active, or both may be in remission.

In the general population, about 13% have experienced alcohol abuse or dependence at some time during their lives, and about half of this group also has had a psychiatric diagnosis. Diagnosis of alcohol dependence is five times more prevalent among men than among women. However, the association of alcoholism with other psychiatric diagnoses is more prevalent in women. Sixty-five percent of female alcoholics have a second diagnosis compared with 44% of male alcoholics. Of 1.4 million persons treated for alcoholism in 1987, two-thirds had a current psychiatric disorder in addition to substance abuse.

In 1989 MICA clients in New Jersey comprised approximately 30% of state and county hospital admissions and 17% of community program admissions. Of these admissions, about 20% of all mental health service clients had alcohol problems; about 9% had problems with drugs. In contrast, about 5% of mental health service clients in the general population have alcohol problems and 2% have drug problems. Between 1984 and 1989, the proportion of MICA clients rose by 7% in community programs and 4% in hospitals.

Mental health and chemical dependency practitioners have noted a rise in the number of MICA clients during the last ten years. Contributing factors are the exodus of persons from state hospitals to community care and unsupervised living, the increasing ranks of homeless and impoverished persons, and the collaboration between mental health and chemical dependency providers.

In the past, because chemical dependency treatment and psychiatric disability treatment occurred in different settings with different technologies and specializations of health care personnel, these treatments took place sequentially and frequently were contradictory. Therefore, a person who was dually-diagnosed could receive treatment for both chemical dependence and addiction, but these treatments would not take place concurrently, nor be coordinated. These practices of the two systems led to frequent client relapse and contradictory treatment instructions from the two systems to the client and family. Historically, combined treatment did not surface until the mid-1980s.

Another frequent problem (more prevalent in the past but still ongoing) is the difficulty of distinguishing between psychiatric disability and chemical dependency in a client. This occurs mainly because clinicians tend to be trained in one specialty or the other and symptoms mimic and mask one another. For instance, chemical dependency may produce temporary psychoses, hallucinations, paranoia, even suicidal tendencies.

Similarly, psychiatric disability frequently resembles addiction, particularly when the psychotic episode takes place during a period of intoxication. Chemically dependent people frequently experience depression and anxiety as a normal part of withdrawal and adjustment to a life of recovery. For some persons, psychiatric treatment will be necessary. For others, the depression will lift if given time to adjust to the new abstinence lifestyle. Generally, these conditions improve with abstinence and recovery.

Persons who demonstrate addiction have been discriminated against in the psychiatric system, and persons who demonstrate psychiatric symptomatology have been discriminated against in the addiction system. Now, enhanced assessment of clients who are recognized as suffering from dual diagnosis has become available. However, past refusal of treatment and provision of inappropriate treatment to individuals and family members gave rise to the Mentally Ill Chemical Abusers movement.

Denial of the concomitant illnesses continues in both systems. Problems are compounded by misdiagnosis, mistreatment, and myths surrounding the treatment of each disability. There are more relapses with MICA clients, more problems with mediation and treatment compliance, and more resistance. Families report that they suffer from a double stigma and strong denial.

Individuals with a lifetime history of psychiatric disability and addiction have elic-
ized adverse public reaction due to homelessness and perceived antisocial acts and bizarre behavior. Therefore, communities have demanded more careful scrutiny of both addiction and psychiatric agencies. However, service agencies are faced with medical and legal conflicts. At times, the treating professional knows that the dual illness is not under control, but, if the client has not done anything to require commitment, treatment is unavailable. Treatment technologies in both systems are changing to accommodate MICA needs. The addiction system has become more open-minded about referral to self-help groups and the need for blood, breath or urine testing.

Appropriate differential diagnosis and cross-training of mental health and addiction professionals are essential. At the present time, there are many gaps in the continuum of care. Many treatment services remain inappropriate. MICA clients face discrimination. Agencies protect turf and territoriality, depending upon funding streams and technical skills. The costs of mismanagement are enormous. Mental health emergency services see persons who are not in stable recovery from the chemical dependency. Chemical dependency programs experience more relapse because of unstabilized psychiatric disability. Treatment is driven by the therapist's approach and the agency's philosophy rather than client needs.

Nearly ten years ago a new publication was developed by a team of recovering psychiatrists which addresses the issues of AA and medication. This pamphlet articulates the problem of psychiatrically disabled individuals attending Alcoholics Anonymous and being admonished to cease taking psychotropic and other prescribed medications. The authors emphasize that there is a subset of the MICA population for whom medication is a necessary and helpful adjunct to treatment and that this group should be supported in their recovery process through 12-Step programs. This pamphlet paved the way for the establishment in New Jersey in 1985 of the first specialized self-help group for persons with dual diagnoses.

Today a treatment protocol for the MICA client is emerging. Practitioners agree that both illnesses must be treated concurrently: (1) the illness will be given priority if the one that is most fluid at the time of admission; (3) stabilization of the psychiatric illness is necessary to deal with the active chemical dependency; and (4) stabilization of the chemical dependency is advised to treat the psychiatric illness.

Family members have organized associations for mutual support and to advocate on behalf of MICA relatives. Renewed attention, funding, and demonstration projects for specialized treatment of MICA population have resulted. Addressing service needs of the MICA has brought about an emerging partnership and consensus between the mental health and chemical dependence fields. This is reflected in recent federal legislation which mandates nondiscrimination in service provision to dually-diagnosed clients in all federally-funded mental health, alcohol, and drug addiction agencies.

...REFERENCES...


Many factors contribute to highway accidents, including roadway and vehicle design, traffic volume, and driver characteristics, such as their state of sobriety. Driving Under the Influence (DUI), or Driving While Intoxicated (DWI) on alcohol increases the probability of a motor vehicle accident. Other related, but less visible, public health risks include walking and boating while intoxicated. The results from experimental and epidemiological studies indicate that alcohol intoxication greatly increases the risk of accidents. Although many sources state that more than half of all fatal accidents involve alcohol, the fact that a driver was intoxicated does not mean that they caused the accident. However, when the intoxicated driver is assumed responsible, the relative risk of "crash probability" (see figure) clearly increases as a function of per cent blood alcohol concentration (BAC).

Other drugs, such as marijuana, may also increase accident risks, but their role in traffic accidents is not clear. For example, in most accidents in which marijuana use was detected, alcohol was also present, usually in large enough amounts so that alcohol intoxication alone could have accounted for the impairment. Even so, many of the effects of marijuana (e.g., memory lapse, distortion of time) intuitively would interfere with the ability to drive safely. The effects of cocaine on driving ability and risk for accident are equivocal at best. Although cocaine may alter vision (e.g., hallucinatory "snow lights," sensitivity to light) and mood (e.g., euphoria, depression, paranoia), at the present time it is speculative as to whether such effects are present to the extent that they will affect driving relationship between alcohol intoxication and driving. Generally, alcohol is a central nervous system depressant that causes a dose-dependent decrease in cognitive and motor functioning. As the blood alcohol level rises, the signs and symptoms of alcohol intoxication increase in number and intensity so that laws restricting drinking and driving are necessary.

Regionally, legislation defining DWI varies. All but a few states have "per se" statutes in which no evidence (e.g., improper motor vehicle operation) other than an alcohol level that is above the "presumptive level" is required for a DWI conviction. The majority of states use a BAC of .10% as a presumptive level, which is "prima facie" (legally sufficient) evidence for drunk driving. Some states use different BACs to define a per se violation. For example, in Georgia the level is .12%; in Oregon it is .08%.

The most consistent profile for drunk drivers is that they tend to be males less than 24 years of age. About twice as many men are involved in fatal motor vehicle accidents when the BAC is greater than .10% compared to women. Other statistical correlations with DWI include being divorced or separated, having a low income, and having a record of previous DWI arrests and previous moving violations involving the use of alcohol.

Numerous laboratory studies have been performed to evaluate the effects of alcohol on psychomotor performance. The results of such studies suggest that alcohol significantly affects vision, eye-hand coordination, and reaction time at moderate-to-high dosage levels. The most relevant driving-related behaviors affected by alcohol are probably divided-attention tasks. Alcohol impairs the ability to pay attention and respond to multiple stimuli. It is believed that such laboratory findings translate well to the real-world driving situations where it is necessary to attend to many different events (road and traffic conditions, speed, traffic control devices, etc.), often in a nearly simultaneous fashion.

On closed-course driving tests, BACs of about .06% to .09% increase variability in lane position, brake use, and steering ability. Using a driving...
For law enforcement purposes, behavioral tests coupled with an objective blood or breath alcohol test provide convincing evidence of intoxication.

When an intoxicated person is given a laboratory test, it is fairly easy to detect intoxication. Even to inexperienced observers, the weaving, uncontrolled stops and other erratic driving that results from alcohol intoxication will be noticeable. However, in the absence of specific tests it is difficult to reliably detect intoxication until the person is well above the legal definition of intoxication. At a BAC of .15% or more, most drinkers will show the typical signs and symptoms often associated with alcohol intoxication (e.g., stumbling, inability to walk stand normally, major changes in speech, mood or thinking). At the level of intoxication, the relative risk for an accident is nearly 20 times greater than when sober. In other words, when you see someone that "looks" drunk, they will not be able to drive a car safely regardless of how they feel or their previous drunk experiences.

Selected References


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In virtually all societies that permit the use of alcohol, women as well as men are permitted to drink socially, although women generally drink less frequently and in lesser amounts than do men. In the United States, epidemiological studies show that the percentage of women who drink has remained stable over the last several decades. There are differences, however, in patterns of female drinking in the general population, varying with age, education, marital status, income, employment, race and the drinking status of the woman's spouse or lover. The changes in alcohol use by women over time indicate a trend toward higher rates of heavy/frequent drinking among young women; women in their twenties now show a higher rate of heavy drinking than other cohorts who were measured at the same age in the past. Young women appear more frequently in the drinking-and-driving statistics than they used to. Still another reflection of this trend appears in the lower average age of women now entering treatment facilities for alcohol-related problems, an average age lower than has been true in the past.

Attitudes toward female intoxication remain generally negative and a double standard prevails: an intoxicated woman is perceived as "worse" than an intoxicated man. This disapproval, which has persisted despite other changes in women's status (e.g., more women in the workplace, more sexual freedom) may be based on impairment in nurturant behavior, perceived greater sexual availability, or perhaps the greater likelihood of overtly expressed anger. Despite some recent shifts in sexual stereotypes, overt expression of anger or sexuality by women is still frowned upon. Whatever the reason, negative attitudes toward female drunkenness persist.

Why do some women develop alcoholic abuse or alcohol dependence? Theories about etiology include: genetic endowment, inadequate personality mechanisms to cope with life stresses, depressed affect, problems in impulse control, traumatic events and losses, and heavy drinking persons (parent, husband, sibling, friend) in the social environment. Depression has long been associated with alcoholism in women but it is unclear whether depression precedes or follows the drinking. There is some research evidence, albeit retrospective, that women who develop alcohol problems as adults are more likely to have depressed feelings of being unloved and deprived, in childhood and adolescence, than women who do not develop drinking problems.

Alcoholic women are a heterogeneous group, differing by age at onset of drinking, ethnicity and social class, sexual orientation, use of other drugs, availability of social supports, and accompanying psychiatric symptomatology. Comparing the alcoholic-dependent woman with the alcoholic-dependent man, there are some commonalities, e.g., alcohol-related medical problems. There are also male/female differences. Among women with drinking problems:

(a) Positive family history is reported more frequently by women;

(b) The process of becoming an alcoholic is of shorter duration;

(c) The woman's spouse or lover is more likely to be a heavy/problem drinker than is true of the spouse or lover of the male alcoholic;

(d) Marital disruption is more likely;

(e) The combination of alcohol and psychoactive medication is more usual although the use of illegal drugs is less than among males;

(f) Dual diagnosis patterns show a higher frequency of neurotic disorders; among male alcoholics, antisocial personality (ASP) is more frequently the other diagnosis.
(g) Drinking is more likely to occur in private places and is more likely to be solitary drinking.

(h) Hepatic disorder appears proportionately more frequently among women while delirium tremens and alcohol-related accidents occur more frequently among male alcoholics.

(i) There is a risk of fetal effects of heavy drinking and, interestingly enough, the question of fetal effects of the male’s heavy drinking has also been raised; and

(j) Barriers to seeking help and to staying in treatment are thought to be greater.

Barriers to seeking help for women include financial problems, childcare responsibilities, social stigma, and family pressures. There are few gender comparisons in treatment outcome studies, but it is generally believed at this time that prognosis is similar for both sexes. Families may be supportive or nonsupportive; where they are supportive, reconstruction of familial and other social networks is a priority. Alcoholic women may also need help with health problems, job training, effective parenting, and in establishing social networks which discourage return to alcohol. Women with alcohol problems who are members of ethnic minorities will probably benefit from ethnic-sensitive counseling.

Prevention of heavy drinking and alcohol problems among women may be linked either to antecedents (primary prevention) or to consequences (secondary prevention). Prevention strategies for women directed toward moderate drinking are needed.

References


Readings for Further Information


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NCADD FACT SHEET: ALCOHOLISM AND ALCOHOL-RELATED PROBLEMS

Alcoholism is a primary, chronic disease with genetic, psychosocial and environmental factors influencing its development and manifestations. The disease is often progressive and fatal. It is characterized by continuous or periodic impaired control over drinking, preoccupation with the drug alcohol, use of alcohol despite adverse consequences and distortions in thinking, most notably denial. ¹

THE SOBERING FACTS: AN OVERVIEW

- Despite a decline in per capita consumption of alcohol during the 1980s, overall alcohol-related morbidity did not decline.²

- As many as 10.5 million Americans show signs of alcoholism or alcohol dependence, and another 7.2 million show persistent heavy drinking patterns associated with impaired health and/or social functioning. By 1995 alcohol-dependent adults will number 11.2 million, with the number of persistent heavy drinkers remaining stable.³

- Alcoholism and related problems cost the nation an estimated $85.8 billion in 1988, $27.5 billion more than illicit use of other drugs. 39% is attributed to reduced productivity and 33% to mortality losses.⁴

- An alcohol-related family problem strikes one of every four American homes.⁵

- Twin and adoption studies have provided evidence for the genetic transmission of vulnerability to alcoholism.⁶

- An average of 300 people died each day in 1987 from alcohol-related causes—a total of 105,095. Each victim lost 25.9 years of life on the average.⁷

- Fetal alcohol syndrome (FAS) is one of the top three known causes of birth defects with accompanying mental retardation—and the only preventable cause among those three. FAS can be prevented by abstaining from alcohol consumption during pregnancy.⁸ (For more information, see NCADD’s Fact Sheet on Alcohol-Related Birth Defects.)

- About a quarter of all hospitalized patients have alcohol-related problems.⁹

- A survey of 1986 deaths found that men who regularly drank two or more drinks a day were nearly twice as likely to die before age 65 than men who drank 12 or fewer drinks a year; their female counterparts were three times as likely to die before age 65.¹⁰

- Alcohol is closely linked to suicide. Among causes of death in alcoholics, an average of 18% are due to suicide. About 21% of suicide victims are alcohol-dependent.¹¹

- Of offenders convicted of violent crimes, 54% of the inmates in one survey had used alcohol just before the offense. Broken down into different crimes, that’s 68% of inmates convicted on manslaughter charges, 62% on assault, 49% on murder or attempted murder and 52% on rape or other sexual assault.¹²

CONSUMPTION RATES AND PATTERNS

- Per capita consumption was 2.54 gallons of pure alcohol in 1987, roughly equivalent to 36 gallons of beer, 20 gallons of wine or six gallons of distilled spirits.¹³

- Two thirds of the population drink, but 10% of all drinkers (those who drink most heavily) drink half of all alcohol consumed.¹⁴

- Thirty-five percent of high school seniors have had five or more drinks in a row at least once during the two weeks prior to a national survey.¹⁵ (For more information, see NCADD’s Fact Sheet on Youth and Alcohol.)

“GOVERNMENT WARNING: 1) According to the Surgeon General, women should not drink alcoholic beverages during pregnancy because of the risk of birth defects. 2) Consumption of alcoholic beverages impairs your ability to drive a car or operate machinery and may cause other health problems.”

— Warning label required by federal law on beer, wine, hard-liquor and wine-cooler containers, effective November 1990.

(For footnote attribution, please turn to page 4)
ALCOHOL AND ACCIDENTS

- Off the highway, alcohol contributes to about six million non-fatal and 15,000 fatal injuries at home, at play or in public places.  
- In the workplace, up to 40% of industrial fatalities and 47% of industrial injuries can be linked to alcohol consumption and alcoholism.  
- Alcohol is closely connected to the four leading causes of accidental death in the US: auto crashes (about half are alcohol-related), falls (17-53%), drownings (38%), and fires and burns (37-64%).

**Accidents on the road**
- Close to half of all fatal highway crashes are alcohol-related; 23,352 people died from alcohol-related crashes in 1988.
- Two out of every five people in the US will be in an alcohol-related crash in their lifetime.
- One of every three truck drivers who died in highway accidents had used alcohol or other drugs.
- In 1988, 1.8 million arrests were made for drinking and driving, nearly double the number in 1975.

**In the air**
- In a study of flight performance, pilots were given enough alcohol to produce a BAC of at least .10, then observed 14 hours after their last drink, when they had an undetectable BAC. They showed decreases in precision and accuracy on all variables tested. (Federal rules prohibit flying within eight hours of consuming any alcoholic beverage and while having a BAC of .05 or more.)

**In the water**
- Alcohol use was associated with 32-64% of recreational boating deaths in 1983, estimates the National Transportation Safety Board.

**On the tracks**
- A study of drinking practices among 234,000 railroad employees found that 44,000 (19%) were problem drinkers. Between 1975 and 1984, alcohol- or drug-impaired employees were implicated in 48 train incidents that resulted in 37 deaths, 80 nonfatal injuries and $34.2 million in damage.

SPECIAL POPULATIONS

- Although overall drinking levels were lower among African Americans than among whites in a 1984 study, African American men reported higher rates of drinking-related medical, personal and social problems. Between 1979 and 1981, the incidence of esophageal cancer for 35- to 44-year-old African American males was 10 times that for whites; and cirrhosis deaths are still disproportionately high among African Americans.
- African American women between the ages of 15 and 34 are six times more likely (and Native American women 36 times more likely) than white women to have cirrhosis of the liver. (For more information see NCADD's Fact Sheet on Alcoholism. Other Drug Addictions and Related Problems Among Women.)
- The 1985 alcoholism mortality rate for American Indians and Alaskan Natives was 26.1 deaths per 100,000 population, four times higher than for the general population.
- Although Asian Americans are more likely to abstain than members of other racial groups, Asians appear to be drinking more in volume and frequency, according to a 1987 study which cited variables such as specific ethnic group, place of birth and degree of acculturation.
- Among the general population the 35- to 44-year-old age group accounts for 19% of all alcohol related deaths; among Hispanics the proportion is 31%.
- An estimated 20-45% of the 3 million Americans who experience some type of homelessness each year have alcohol problems. The homeless are already at high risk of health problems and psychiatric disorders, and alcohol use exacerbates both.
Alcohol-related problems in the older population may go undetected and untreated. Hospital data shows that from 1979 to 1985, those 65 and older who entered the hospital for non-alcohol-related reasons ended up with alcohol-related diagnoses more often than any other age group that entered for non-alcohol-related reasons.32

ALCOHOL AND OTHER DRUGS

- Alcohol users—particularly women and younger drinkers—frequently use other drugs. Close to half (46%) of Alcoholics Anonymous members, up from 38% in 1985, reported addiction to other drugs as well as alcohol.33

- Over 90% of all alcoholics are heavy cigarette smokers.34

TREATMENT

- Approximately 1.2 million of the estimated 17.7 million Americans with alcohol problems entered alcohol treatment programs. Of those admissions 77.5% were men, 32% between the ages of 25 and 34, 69.7% white, 17.2% of African origin and 6.4% Hispanic origin.35

- Successfully treating alcohol problems costs ten times less than the current cost of alcohol problems to society.36

- Treatment options are not equally distributed throughout the US. Differences unrelated to the prevalence of alcohol problems across the states are found in treatment capacity, distribution of care and per capita expenditure of funds. For example, any type of specialty treatment is 11 times more available in Alaska than in West Virginia.37

ALCOHOLIC BEVERAGE INDUSTRY: MARKETING A LEGAL DRUG

- Consumers spent nearly $88 billion on alcoholic beverages in 1988—51% on beer, 35% on distilled spirits and 14% on wine.38

- In 1989 the alcoholic beverage industry spent $1.2 billion on advertising, more than that spent by the household equipment and electronic entertainment industries combined. Also, three of the top 25 spot television advertisers produce beer.39

PUBLIC POLICY RECOMMENDATIONS

- Drinking and Driving: Make driving illegal per se at a BAC level of .08 recommends the Surgeon General's Workshop on Drunk Driving. Driving with any alcohol concentration presents an increased hazard to the driver and public.40

- Federal Taxes: Equalize federal excise tax rates by ethanol (pure alcohol) content across all beverages by raising rates for beer and wine to that of distilled spirits, recommends the Surgeon General's Workshop on Drunk Driving. Research shows that if alcohol in beer had been subject to the same state excise taxes as alcohol in distilled spirits, the number of 18- to 20-year-olds killed in motor vehicle crashes from 1975-81 would have been 21% lower.41

- Insurance Coverage for Treatment: The Institute of Medicine recommends that coverage for treatment of alcohol problems be governed by the same principles as coverage for physical problems.42

- Pregnancy and Addiction: Shift legislative attention away from punishing and prosecuting pregnant women addicted to alcohol and other drugs. recommend the American Medical Association and the American Academy of Pediatrics. Rather, concentrate on providing these women with the care, treatment and information they need.43

- Warning Messages: 74% of adults favor health warnings on ads for alcoholic beverages, according to a Gallup-Advertising Age poll. Almost half (42%) felt alcohol advertising should be banned altogether.44

- Youth and Advertising: The Surgeon General's Workshop on Drunk Driving recommends eliminating alcohol advertising and promotions on college campuses, where a high proportion of the audience is under the legal drinking age.45
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**WHAT IS NCADD?**

NCADD is a national nonprofit organization combating alcoholism, other drug addictions and related problems through its National Office. 200 state and local Affiliates, and thousands of volunteers in communities throughout America. Founded in 1944, NCADD’s primary mission is education, prevention and public policy advocacy.

NCADD provides education about alcoholism and other drug addictions as treatable diseases; offers prevention programs for schools, organizations and communities; dispenses medical scientific information; answers questions from the public, legislative bodies and the media; and distributes a variety of publications. NCADD also offers information and referral services to children, teenagers, and adults seeking help with alcoholism, other drug dependencies, and related problems.

NCADD sponsors Alcohol Awareness Month in April and Alcohol- and Other Drug-Related Birth Defects Awareness Week beginning of Mother’s Day each year. People seeking more information about the work of NCADD and/or referral can contact an NCADD Affiliate in their area or use NCADD’s national toll-free help line: 1-800-475-HOPE.

**NATIONAL COUNCIL ON ALCOHOLISM AND DRUG DEPENDENCE, INC.**

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RELAPSE PREVENTION AND THE CHEMICALLY DEPENDENT ELDER

Debra C. Barsell, LCSW, NCAC II

In working with older chemically dependent clients, counselors must deal with unique treatment issues in preventing relapse that do not apply to other populations. The process of aging and the deterioration of social and physical abilities mandate that treatment for the older chemically dependent client will take longer than for a younger counterpart. The therapeutic approach will more than likely involve treatment of various co-existing physical and/or mental disorders, such as arthritis, chronic pulmonary disease, diabetes, depression, and anxiety, as well as medication management. Clinical practice with this population, therefore, requires desire, flexibility, sensitivity, patience and honest introspection on the part of the treatment professional.

Approximately 33% of alcoholics over the age of 55 are termed reactive, situational or late-onset alcoholics who have developed addictive problems later in life as a result of the stresses and losses associated with the aging process. The remaining two-thirds of this population are classified as chronic or early-onset alcoholics who began abusing early in their histories. Within this group, some are characterized as “survivors” who have chronic heavy drinking patterns while others are “intermittent” abusers who abuse during times of stressful life situations.

Treatment Approaches

Neither early or late onset elderly clients come to the attention of addictions professionals through the usual referral networks, such as employers, the courts, spouses or families. Since older clients may no longer drive, be employed and may be living alone as a result of spousal separation or death, they are often outside the mainstream of society.

The primary route of intervention, therefore, is through the medical profession as a result of physical health concerns. However, many health care practitioners fail to diagnose the primary disease of chemical dependency in favor of treating secondary psychological and physiological symptoms. When an older chemically dependent person does come to the attention of the counselor, care must be taken to effect a therapeutic strategy that has the best opportunity for success.

Networking with hospital social workers can result in shared information and better mutual referrals. Counselors should take advantage of the fact that hospital social workers are trained case managers who routinely network with available resources for the benefit of their clients which makes them an invaluable resource for services available to the elderly within the community.

Discharge planning for the older client must begin from the date of admission. Services networking and good case management will be crucial to a positive treatment outcome. Issues such as transportation, previous involvement with formal support systems, availability and previous use of informal support systems, financial status, and housing will be significant in the early development of a treatment plan.

The goals of therapy for the older client must be to stop abusing alcohol and/or drugs, to properly manage prophylactic or maintenance medications, to regain or establish self-identity and re-socialization. The usual labeling process, “I am an alcoholic,” may be self-defeating for this population. The perceived stigma due to age considerations, such as prohibition and a view of alcoholics as derelicts or weaklings, may undermine the therapeutic value of labeling.

Upon implementing a treatment plan for a chemically dependent elder, it must be remembered that a retrospective approach can be help-
ful with this age group. The older client has more investment in the past than expectations for the future, and a life review can help to move the client into the present. The client can either write or audio tape an autobiography which the counselor can use as a tool to discuss identified gaps in the life span presentation or other areas of concern during individual sessions. Trust in the therapeutic relationship can be developed through the validation of the client’s history which helps to humanize the treatment process as the counselor gently navigates the client into the present.

The counselor’s style and technique are important to successful interventions with the elderly. A counselor’s style needs to be more gentle than that which may be used with the younger client. Structure is important to help orient the cognitively impaired, and behavior modification techniques can be used successfully, particularly with the late-onset addicted individual. It is essential for the counselor to be consistent with the older client, and more frequent use of the individual session may be necessary. The therapeutic relationship must be established as being safe, confidential, and a place for sharing deficits.

It is recommended that the senior in recovery be connected with a sponsor early in the treatment experience. A person within the same age cohort would provide the best model for the newly recovering elder. If any age-specific fellowship meetings are available, the older client should attend. It should be remembered that sex-specific groups are just as important as age-specific exchanges.

Counselors must also be aware of the physiological changes in the older client. With age, there occurs a circulatory shift where the blood supply to the heart and brain is favored over that to the kidneys and liver. Therefore, detoxification and excretion of alcohol and other drugs are slower, due to decreased kidney function and circulatory changes. The involvement of organicity, such as an organic brain syndrome, must be evaluated to properly develop an appropriate continuing care plan.

Importance of Resources

The continuing care plan of the older client will change as his/her capacities expand. Exploration of the most primitive needs of the client, such as shelter, food, and clothing, may be necessary within the early stages of treatment. Informal support systems, such as families and friends, may need cultivation if they still exist. Formal support systems also need to be tapped to provide the services that are basic to the client’s existence.

Networking with a local department of aging or the Area Agency on Aging (AAA) is a way the counselor can identify the services available to senior citizens. Mandated under the Older Americans Act, Area Agencies on Aging are located throughout the country and can provide sources of senior information and referral services.

Other services that are available to seniors, particularly in metropolitan areas, include: activities centers, volunteer programs, telephone reassurance, home delivered meals, housing, home health aides, Supplemental Security Income through the Social Security Administration, talking books for the visually impaired, adult protective services, and adult day care. All can be found in any telephone directory.

Special Treatment Issues

As stated before, older chemically dependent clients have unique treatment issues which must be addressed in order to provide maximum benefit from treatment. These issues include:

Hearing Deficits: Because many older clients suffer from hearing loss, group situations can be more difficult to follow, resulting in frustration, hostility or paranoia on the part of the client. Since the lower pitch of the male voice can be heard more distinctly, male counselors, when possible, should be assigned to those elders with hearing deficits. Hearing deficits also may increase individual therapy time. In addition, the client needs to be guided to ask group members for their assistance in facing the hearing impaired person, keeping obstructions from their mouths when speaking, and eliminating background noises. Turning up the volume is not an effective approach to being heard by the elderly.

Vision Deficits: Decreases in visual acuity with age increase the need for brighter lights in treatment areas for the elderly. Reading difficulties due to poor sight may necessitate the use of audiotapes for bibliotherapy. Decreased peripheral vision with age may require the counselor to physically approach the client frontally as an approach from the side or back may be startling. The blue-green color spectrum fades for the elderly which increases their responsiveness to shades of red, yellow, and orange. Therefore, establishing rapport with an elderly client may be easier when the counselor wears appropriately colored clothing.

Tactile Deficits: Since group rooms are usually kept cool, older clients will need to wear sweaters to therapy sessions in order to maintain body temperature. It must also be remembered that what might be a therapeutic hug with a young person could break the bones or bruise the skin of the older client. Not only emotional but physical gentleness are required with this population.

Deficits in Smell: Routine hygiene practices must become treatment expectations as some older clients are unable to smell themselves due to a reduced number of olfactory nerves. If a client’s body odor is offensive to others, social consequences can occur which will negatively impact treatment outcome.

Nutrition: Nutrition practices for
the older client can be negatively affected by the olfactory involvement in the appreciation of eating. Food presentation can help to overcome the decreased enjoyment of meals. If the older client is in an inpatient or residential setting, staff can expect complaints about the food and they must be ready to explain why food has become less appealing.

Loses: The losses associated with aging are significant and can be depressing. Not only do the losses of family and friends produce psychological and behavioral results, but physiological and social losses, such as loss of mobility, perceived beauty, and health have profound negative influences on self-esteem. These issues must be addressed in treatment.

Attendance: Special considerations must be given to the time of appointments and meetings. Therapy groups and individual sessions that are held during the day or early evening hours will meet with greater senior attendance. For those seniors who are unable to leave their homes due to physical disabilities, volunteer groups coupled with the counselor’s creativity are key ingredients in a successful treatment plan. The counselor can establish regular telephone therapy groups which should occur at a specific time, have specific discussion topics and be time limited. This approach can be extremely valuable in that sensitive subjects can be discussed openly with a degree of anonymity.

Informal Support Groups: It is widely held that family members abdicate their responsibility for assisting elderly relatives. This is false. Most families provide as much informal support as they can, and family counseling is an essential part of treatment to help family members rebuild or improve relationships with the recovering senior.

Conclusion
The recovery potential of the chemically dependent elder depends on the quality of the continuing care plan that is negotiated with the client. Appropriate medical management and socialization issues are critical to the recovery process.

Through the development of a comprehensive continuing care plan, the counselor helps the client to identify needs and balance actions to support abstinence, health, improve quality of life, and relapse prevention.

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References
Dear Dr. Brothers: Why do my parents, who are both in their 70s, quarrel so much? They never used to do this. I don't want to take sides, but at times, I feel perhaps I should. I also think they're both drinking more than they did in the past. What should I do? — V.N.

Dear V.N.: Try not to get personally involved in their quarrels unless you see that one of them is being really injured. Elderly couples argue for a variety of reasons and, without knowing them personally, I could not say what the cause is. However, if they're drinking more, that could definitely be a factor. Usually, people their age are on other medication, and when alcohol is mixed in with this, the results can be disastrous.

Tell your parents how you feel about their arguments and their drinking. Remind them that it isn't that unusual for people to develop alcoholism in later years. If they have any doubts, suggest Alcoholics Anonymous.

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A number of primary issues recurred throughout my interviews with older women recovering from co-dependence. A discussion of these issues follows here and in Chapter 5.

Discarding Traditions and Myth-Mandates

Important for older women in recovery is the conscious rejection of traditions that have long unconsciously entrapped them. Some must quit roles or jobs that have given them the little, yet oftentimes only, power they have felt in their families. These include, for example, the roles of “broadcaster” or “publisher” of family gossip, or “switchboard operator” to communication among family members. For many mothers relinquishing the pivotal position of
“counselor mom” is anathema in early recovery. Not to be able to mediate among her offspring who are quarreling with each other seems at first an impossible task. But it is a very important one. Said 58-year-old Miriam:

The most painful thing I ever had to do as a mother and recovering caretaker was to stand up in my living room in front of my six adult kids and tell them, “I have nothing left to give you.” And as horrible as that sounded to me, I knew somewhere deep within me that it was healthy to say it.

The recovering older woman must let go of the importance of her reputation as a “good wife” or “good mother” and remain true to her own truth, what she defines as her own essential goodness. Said Samantha, 63 years old, recovering from what she described as “self-worth deprivation”:

The hardest part for me was learning I could love myself without having egomania, that self-esteem does not mean that I am lacking humility or that I am being grandiose or too big for my britches.

Many traditions are carried on in statements, attitudes and behaviors passed on to us at an early age and reinforced in our families and society as a whole. Unexamined, they assume the status of myths and, worse yet, gain power as mandates that must be followed in order for us to live correctly as the “good woman.” The recovering older woman is in possession of many such myth-mandates that need examination and in many cases expunging. The following were described to me by older women interviewed for this book:

- You are not to talk about problems in the household and, for God’s sake, at the same time be a good tattle-tale!
- Children are supposed to take care of parents when their parents get old.
- A good wife should be a good cook and homemaker and a selfless parent.
- A good mother sacrifices her time and energy and personal needs for the sake of her family.
- A good woman always looks like a lady. That is, she keeps her legs crossed, her hair done, her lipstick on straight and her slip doesn’t show.
- A sweet little woman never complains or nags her husband. (Simple reminders are tantamount to nagging.)
- Husbands are always right or should be made to think they are.
- A woman should be honest at all times, but never so honest as to deflate her husband’s ego.
- A good wife never goes to bed angry.
- Give your last cent to your family if they need it.
- A good wife is in charge of the couple’s social life.
- Men should make more money to feel more powerful.
- All good parents love their children.
- All good women get married and live happily ever after.
- The man is supposed to be the boss.
- A good wife gives her husband sex when he wants it or he will get it somewhere else.
- The good woman’s job is to fulfill the mandate given by her husband, the master. And then he will take care of her.
- Good women are ladylike. Ladylike means passive, inferior, agreeable and co-dependent.

Shame, Secrets And Shoulds

The older woman’s three main points of connection to continuing dysfunction are shame, secrets and shoulds. They are her reasons for being, her family’s and society’s questionable gift to her.

For me the high price of serenity is the telling of all my secrets. Secrets cause shame, and shame in turn demands more secrets. To hide them both, we employ the use of shoulds. A woman’s secret may be that her father beat her mother. She feels ashamed. She tells herself that she
should not talk about it to anyone. Then, in a not unusual scenario she marries a man who beats her. Again, it is a shameful secret, the bruses of which she covers up by saying that she fell down the stairs.

One of my own most carefully guarded secrets is as old as my childhood: I never felt I belonged anywhere, not even with my family. This secret of mine is attached to ageist attitudes. The source of my shame: as a child, I was extremely embarrassed that my father was old enough to be my mother's father. This fact was so painful to me that I began to tell lies about my parents to strangers. Through fabrication and embellishment I was able to invent a more pleasing and acceptable picture of my family, the kind of family we "should" have been. By normalizing my family statistics I was able to feel that I belonged.

One of my interview subjects revealed her painful secret:

My Al-Anon group [30 women] is filled with women whose biggest secret is their disappointment in their marriages... the failure of their spouses to keep their promise to "take care" of them and their children. One by one we have lost our big homes in Great Beach, and one by one we have been made to look at our "looking good" issue through coming upon each other working in drugstores and florist shops for $4.50 an hour. We're just too proud to admit we have no money, that our alcoholic husbands had failed. We've been listening to each other's excuses and rationalizations for why we're waiting tables or selling greeting cards in a novelty shop "just to keep busy." We've been lying to each other, lying to our own best friends! Now, that's really sick.

Secrets, shame and shoulds can kill us. One of my clients, 58-year-old Betty, was filled with them. I had begun to introduce her to the steps of co-dependent recovery as she was unable to remain abstinent from alcohol without addressing the caretaker issues that formed the core of her addictive behavior. One day she stomped out of my older women's group for Adult Children of Alcoholics, yelling over her shoulder, "I don't want to look back. Let the dead bury the dead." Today, Betty is dead. Unaddressed, unrevealed secrets fester and grow. They keep us from being honest with ourselves and intimate with others. Ultimately, they keep us trapped in our deadly dysfunction.

Dysfunctional families are filled with secrets. Many of them — Granddad couldn't read, Uncle Bob is gambling away his family's nest egg, Aunt Mary wasn't married when she got pregnant — are not obvious and must be pursued vigorously. Some we shall never learn — is it true that Great-great-grandpa abandoned a wife and family in Poland to start a new life, with a new wife, in America? — so complex and entrenched are they. Family secrets are nurtured until they have become part of the family's moral fiber, binding it together. Secrets become inculcated into the dysfunctional family's closed system and branded into each member's set of values as family policies, laws executed in the family through hierarchal competition and the ever-present threat of failure. The consequence of telling the secret is punishment by other family members, while the consequence of dutifully keeping the secret is a kind of enforced ignorance that is anything but blissful.

Dorothy, 70 years old, revealed to me that a big secret in her family was that she and her sisters were bulimic 50 years ago. She spoke with shame and anger about the "puke pit" in their backyard that all three sisters used when they were in high school so as not to gain pounds after enormous family dinners. Their parents were both weight-conscious. Demeaning their children verbally for being fat was used in their child-rearing as both punishment and threat. Today, all four of Dorothy's daughters are obese, carrying the weight, literally, of their mother's shame.

Another woman I interviewed talked about her husband who kept her informed for 25 years about his ongoing extramarital affairs. But when she had an affair of her own, he told her that infidelity was permissible for him but not for her. "Do you think I ever told my kids about
any of that?” she asked me rhetorically. “Of course not. I always wanted them to think that their dad was a good guy. I never wanted to cause them the pain that they would experience if they knew what he had done. So I kept it a secret but after they were grown, they found out anyway. Then they went into therapy and were angry with me because I had taken out on them, through my stress and the strain of keeping the secret, the pain that I couldn’t express.”

Sometimes we keep a secret so masterfully that we hide it even from ourselves. We call this “freezing the guilty memory.” An example involves two of my clients, Kathy and her mother. Kathy recalled an auto accident in which her father was driving drunk 33 years before, when she was five years old. When she cited this in a therapy session in her mother’s presence, her mother expressed shock at her knowledge of the accident and disavowed that Kathy had even been present. But her daughter was able to describe graphic details of the accident, including the blood on the printed blouse that her mother had been wearing. Upon finally being convinced that Kathy had indeed been involved in the accident, her mother wept convulsively, crying, “My poor baby. I forgot. I’m so sorry. I didn’t know.”

As difficult as secrets are to live with, they are no less easy to reveal. Women more than men, notes alcoholism expert and author Marlan Sandmaler in her book The Invisible Alcoholics, seem to have greater difficulty sharing their secrets. Because they fear that they will appear somehow unladylike, the process of revealing secrets is seen as more stigmatizing to women. But for the sake of our health, reveal them we must.

Following are some of the most well-kept secrets revealed to me by women I interviewed for this book:

- “I wanted to be on the stage, but my stepfather jeered and said I’d be in the third row of the chorus. So I studied domestic science” (from a woman in London, age 70).
- “I hate cooking.”
- “I became pregnant at my husband’s insistence to keep him from having to go in to the army.”
- “I love my children.”
- “I love one of my children better than the others.”
- “My biggest fear is that my husband will become ill and I will have to take care of him. My secret is that I hope I die before he does.”
- “I enjoyed the first orgasm of my life six years ago with my husband” (from an 80-year-old woman in recovery from alcoholism for nine years).
- “I was arrested for nudity at a beach in San Diego in 1935.”
- “I ghostwrote most of my husband’s books. He could not spell and his grammar was atrocious. In 1961 a publisher rejected a book that I wrote. Six months later we resubmitted the same manuscript under my husband’s name, and it was accepted by the same publisher. It was all over for me after that” (from Marjorie, 77, in recovery from alcoholism and co-dependence for eight years and the widow of a famous author).
- “I wrote my husband’s master’s thesis.”
- “Our family secret is that men are weak and women are strong.”
- “Tuberculosis ran in my family.”
- “I love my husband.”
- “I am very angry.”
- “Whenever I wanted to hear my husband tell me that he loved me, I would arrange for us to go to dinner and dancing. The only time he could tell me he loved me was when he whispered it in my ear in public on the dance floor” (from Frances, 81, a widow for 38 years, sober 16 years, who had her first drink after the death of her husband).
who was so abusive to both her and her children. From that point on, until she began her recovery from co-dependence, she went into a kind of amnesia, or trance, during which she actually believed that all the harm he had done had not really happened.

Entire families are known to block out the abuse from their consciousness. This serves two purposes: the family members can avoid dealing with the pain they carry, and they can continue to be proud of their family heritage. They do not have to admit that theirs may have been a family that they can no longer boast about. But before we blame them, let us remember that this is just another form of denial, called repression, that comes with the disease of co-dependence. Such a family is not lacking in dignity but lacking in health. Said Eleanor:

It was only when I discovered my grandkids were getting the same kind of brutal treatment from their fathers that my husband had given them that I decided I’d better learn something about my own part in the abuse to my kids. That’s when I went into treatment, and my own kids were called in for family sessions, and now everybody’s in treatment. It is painful, but my grandchildren are not going to be abused again, and I’m hoping they’ll grow up to be healthy parents. We’re all trying.

Myths about family saints are passed along to us as children in our families of dysfunction. We grow up believing lies. In many households dead perpetrators of physical or emotional battering or even incest are blameless by mere virtue of the fact that they are dead. It becomes the distorted reality of their descendants, then, that any impurities in the family could only have been spontaneously generated in the present. We, the living, are pinned with full responsibility for whatever problems manifest themselves in our lives, from drug abuse to wrecked marriages, even though the patterns of such difficulties may have been in formation generations ago.

In our recovery we must challenge the status of family saints, peering beneath their glowing aura to the true essence of their existence. The family secrets that many of these people took to their death are valuable items of family history, information that we may make use of in our own lives for understanding, intervening in and preventing disease. Some families may label discussion of these secrets as shameful family gossip. But this is anything but gossip. This is a search for truth. In the same way that physicians seek their patients’ family history of cancer, heart disease or diabetes in order to be forewarned of potential disease, it is beneficial for descendants of the deceased to discuss the person honestly in order to trace patterns that are passed down genetically and through family socialization.

Genealogical Charts

Knowing the truth about family saints also proves useful in resolving harmful family conflicts. Many a funeral hymn has been sung with dark clouds of disharmony gathering in the dissident distance. To speak candidly of family quarrels is considered heresy in some families, but this is the route to resolving once and for all unfinished business between the deceased and the survivors.

Genealogical charts, including emotional family trees, are a very helpful tool for deciphering the pain passed down by family saints. I suggest to most of my clients that they do their own genealogical chart.

To do one yourself, on a large piece of paper chart information regarding family members, tracing back at least to your grandparents or further if you can remember or can gather information.

This is not strictly a factual chart. You need to present wherever possible such demographic data as each person’s name, sex, date of birth and date and cause of death. But this family tree also traces emotions. Include yourself in the chart at whatever age you would like to be, then place your relatives and significant others close to you or at a distance, depending on how you experienced them emotionally. While you’re at it, write one or two of your feel-
ing adjectives — affectionate, angry, depressed, optimistic, etc. — beside the name of each family member. In this way you will be better able to determine those persons in your family, living or dead, with whom you still carry unresolved issues.

Interestingly, despite the doggedness with which many families hide their secrets, most are quite willing to reveal factual information if they view doing so as an assignment. This is one way, in fact, that mothers can help their children in recovery, by revealing the family secrets.

The Alcoholic And Abusive Marriage

One question I asked during my interviews for this book was, “What were the most painful years of your life?” Distressingly, literally dozens of women said that those were the years when they were married to alcoholic and abusive husbands. They continued to stay with those husbands, they said, because doing so was better than the feared alternative: poverty and the inability to sustain their lives and the lives of their children. Some of these women talked about having been physically battered and having their lives threatened. The choice to leave sometimes was available and was considered, but they chose to stay. And for all those years, they felt they were in prison.

Today many of these women in recovery are now divorced or their husbands dead and they feel great relief. But now they must deal with the offspring of those abusive marriages, their adult children who are now very angry that their mothers stayed with their fathers. These women are in a no-win situation. They lingered in the abuse, they believe, to save their children’s lives, but now their children are angry at them for having done just that.

In some cases children of such marriages are angry and confused because their parents divorced. This often results, we find, when the mother had been secretive, hiding from her children the truth about her husband’s abuse. These children had little understanding of their mother’s sordid plight or the degree of her powerlessness. Many women protected their husbands no matter what the repercussions. Said one such woman to me, “I think the children have the right to respect their father regardless of the circumstances.”

Other statements of misplaced loyalty by women I interviewed were quite illustrative of the kinds of attitudes that proliferate in chronically abusive relationships. Among them are these revelations, which some recovering women discovered about themselves:

- “It is familiar for me to think of myself as inferior.”
- “I am comfortable with bad treatment.”
- “I am not comfortable without an oppressive partner.”
- “I have been taught that all criticism is true . . . and the best way to avoid criticism is to do it to others before they do it to me.”
- “Compliments are not to be trusted. I was taught that giving compliments to others, however sincere, was not safe.”
- “Here I am, 10 years after my divorce, still wanting to hear through my daughters whether or not my former abusive husband inquires about me or my well-being.”

Abuse covers a wide range of behaviors, all of them harmful. Emotional downgrading of the sort Loretta, 57, described, is one variety: “Now I know he really did not believe he would ever be successful, and we set it up so I could be blamed for his failure . . . That became the whole script.”

The emotional abuse that an actively alcoholic husband is capable of heaping upon his wife can be deadening. When such a wife is asked what she feels about her husband and she replies that it is not love but is too painful for her to describe — but she cannot leave him — she is a battered woman. At the extreme end of the scale of abuse is black-eyed, broken-limbed, life-threatening physical battering.

Many women in dysfunction feel comfortable only when they experience the abuse. This ironically is the
only time they feel safe. When they are in the center of
the abuse, they know where they are, and they experi-
eence a sense of false control. Being in the middle of it
feels better, or less dangerous, than the expectation and
fear of it.

Clients will sometimes ask me, "Do I have to leave my
husband if he's alcoholic or abusive?" I tell them that the
decision is theirs. They have to make a choice about wheth-
er or not they want to deal with the situation without
having to change or fix their husbands because they are
powerless to change or fix him. They have power only in
their choices and their own recovery. The woman who
chooses her own recovery eventually will need to address
her abusive marriage. As one of my clients, Lydia, 55, said:
'I know that ultimately I will have to leave him or he
will have to get out because the healthier I get, the less
willing I am to tolerate his illness. It is unimaginable. I will
not live with someone who is this sick."

Many alcoholic men leave their wives, often for younger
women. This is common in our culture. Yet as the older
women who have been abandoned recover from their co-
dependence, not a few have told me something like, "I
would like to ask that woman he went to if she'd like me
to take him back, and then I would tell her that I don't
want him back. I'd like to say to her, 'I'm glad you've got
him because I didn't realize what a mess I was in until I
was free of him, until I began to realize that he is not my
Higher Power.' I can take care of myself."

A physically battered woman who tells herself every
day that tomorrow she will leave — or after Joey's birth-
day or after the family reunion or after her youngest
daughter graduates — is only fooling herself. She is de-
luding herself into believing that things will change. May-
be she will get a better job and won't have to leave. Maybe
problems will no longer be her fault, and she can remain
with him. Maybe he will stop hitting her if this time she
does everything perfectly.

Every battered woman who stays in the situation does
so to try to gain validation from the very person who has
robbed her of that validation and who has confiscated
her identity. This is addiction. This is denial. She believes
that she deserves nothing better than what she has. She
rarely knows that she is living in a battering environment.
Tragically until she is willing to pull herself from a situ-
ation in which she is drowning, she is not even aware
that she is drowning. Not until she crawls out of the
ocean does she realize she is exhausted, cold and sopping
wet. To that woman, I would like to say, come out of the
icy water now and thaw out in the sun. You will be safer
in the sun.

Sexual Issues

Recovering older women have numerous and complex
issues related to sexuality. Some women view the manip-
ulation of sex as a means of getting what they want. Said
Elisabet, 56, from Germany:

I do not love my husband. In fact I hate him... My
husband is a perfectionist and a pain in the neck. I am
gentle in bed, and he is no longer impotent, as he was
when I married him. I have to put up with him until
August, when I get my doctoral degree. Then I will be able
to support myself. My gentleness in bed is my only lever-
age with my husband. Sometimes I feel like I'm selling
myself, but I am also a survivor of World War II. I have
received a medal from the German government. I am re-
spected. I have had a hard time.

Also problematic, many women who need and yearn for
connection with others are willing to be sexual in order to
satisfy that need. They believe that being sexual presents
the only opportunity to feel loved. If a woman did not
receive nurture — even in the form of a simple hug — as
a child or in her intimate relationships as a young adult,
she finds it all but impossible to accept nurture as an older
woman. In my therapy groups women who have the most
difficulty receiving hugs are those who have neither chil-
dren nor close relationships with women.
## Alcohol and Prescription Drugs

<table>
<thead>
<tr>
<th>Alcohol Combined With</th>
<th>Can Cause</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sleeping medications (e.g., Halcion, Dalmame)</td>
<td>Excessive drowsiness, impaired coordination, mental confusion, rapid intoxication, loss of consciousness, impaired breathing. Can be fatal.</td>
</tr>
<tr>
<td>Tranquilizers (e.g., Xanax, Valium, Ativan)</td>
<td></td>
</tr>
<tr>
<td>Anti-depressants (e.g., Elavil, Tofraniil)</td>
<td></td>
</tr>
<tr>
<td>Pain relievers (e.g., Percodan, codeine)</td>
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<tr>
<td>Some muscle relaxants (e.g., Robaxin, Soma)</td>
<td></td>
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<tr>
<td>Antihistamines (e.g., Chlor-Trimeton, Benadryl)</td>
<td></td>
</tr>
<tr>
<td>Motion-sickness pills (e.g., Dramamine)</td>
<td></td>
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<tr>
<td>Allergy medications (e.g., Contac, Dristan)</td>
<td></td>
</tr>
<tr>
<td>Some cough/cold products</td>
<td></td>
</tr>
<tr>
<td>Some high-blood-pressure medications (e.g., Aldomet)</td>
<td></td>
</tr>
</tbody>
</table>

| Anti-anginal medication (e.g., Isordil, nitroglycerin) | Dizziness, fainting, lightheadedness, loss of consciousness, falls that could result in physical injury. |
| Some high-blood-pressure medications (e.g., Minipress, Aprosine, diuretics) | Increase in stomach irritation, possible increase in stomach bleeding. |

| Aspirin | |
| Anti-arthritis medications (e.g., Feldene, Naprosyn, ibuprofen) | |
| Potassium tablets | |
| Blood thinners (e.g., Coumadin) | |

| Flagyl | Can cause Antabuse-like reaction (weakness, headache, nausea/vomiting, flushing, rapid heartbeat, difficulty breathing). |
| Oral anti-diabetic medications (e.g., Orinase) | |
| Some anti-fungal and antibiotics agents (e.g., Chloromycetin) | |

| Blood thinners (e.g., Coumadin) | Interference with control of certain medical conditions (diabetes, epilepsy, gout). Can cause change in effectiveness of drug treatment. |
| Anti-diabetic medications (e.g., Micronase, insulin) | |
| Epilepsy medication (e.g., Dilantin) | |
| Gout medication (e.g., Zloprim) | |
Battered Women Population

In 1991, over 3,000 women and their children (nearly 4,000) found safe housing from abusive situations. It is estimated that 200,000 women are abused each year in Georgia, yet only 55,927 crisis calls from battered women were logged in 1991.

According to Qiyamah Rahman of Adult Protective Services, much of the abuse is alcohol related, but we don’t know how often alcohol-related abuse happens. The woman, too, may use alcohol to cope with her beatings and, as a result, she is unable to take the necessary steps toward a violence-free life.

One place which offers help to these women is the Council on Battered Women in Atlanta.

When a woman comes to the shelter with an addiction problem, she must agree to treatment. If her problem is discovered after she becomes a resident, she must go to a substance-abuse program or leave the shelter. She cannot do what is necessary to end the violence in her life without first dealing with her addiction.

Many times, a victim of battering wants to stop abusing alcohol or drugs, but she believes these substances will help her cope with the batterings. The treatment programs available through the Council on Battered Women teaches healthier techniques for coping.

Know Your ABC’S: Alcohol + Battering = Crisis.

Contact information:
Council on Battered Women
P.O. Box 54383
Atlanta, GA 30308
(404) 870-9600

Senior Citizen Population

There are 18 million people in the United States age 65 and older. Among them, 2.7 million have some problem with alcohol.

Senior citizens may become desperate, alienated, physically and mentally sick. Many lose their spouse and all lose their friends. As their physical problems increase, often they can’t take care of themselves and must move into new living arrangements. The experiences of loss and change are stressful. For some, alcohol becomes a way to cope with the problems of old age.

If an older person has something to do and finds a way to remain useful, he is less likely to turn to alcohol. Some older adults teach others how to care for the elderly, thereby becoming involved in their own quality of life. Some participate as foster grandparents; others work with the schools helping latchkey kids. These older people make an important contribution to our society while adding to their own self esteem.

Most older people cope and adapt to changes and losses without resorting to the use of alcohol and other drugs. Those who turn to substance abuse need assistance. Medical personnel, alcoholism counselors, support groups, alcohol treatment centers, community treatment programs and special services (visiting nurses, meals-on-wheels, etc.) offer help.

The over-65 population will increase in the next nine years. Some will use alcohol or other drugs to relieve the depression and loneliness which come with growing old.

Everyone should be aware of the signs of alcoholism:

- hiding drinking
- drinking more with less noticeable effects
- memory gaps
- confused
- unwilling to discuss drinking
- drinking to calm nerves, forget worries or reduce depression
- aggressive or abusive
- poor diet
- frequent car accidents
- falling repeatedly
- appearing depressed
- withdrawing from social activities
- chronic daytime sleepiness
- talking about or attempting suicide
- neglecting home, bills or pets
- neglecting appearance and hygiene

For a support group in your area, contact Women for Sobriety at (800) 333-1606. The American Association of Retired Persons (AARP) in Atlanta also offers information for the elderly at (404) 888-0077.

Contact information:
Jim Granade, Consultant
Prevention Resource Center
878 Peachtree Street, NE, Room 319
Atlanta, GA 30309
(404) 894-6360
ALCOHOL ILLNESSES
CITED AS BIG COST

Study Says Elderly's Drinking
Causes as Many Hospital
Stays as Heart Attacks

CHICAGO, Sept. 11 (AP) — Alcohol-related medical problems put older Americans into the hospital more often than heart attacks and cost taxpayers more than $230 million a year in hospital bills paid by Medicare, a study has found.

More than 87,000 Medicare hospitalizations were related to alcohol in 1989, researchers said in the current issue of The Journal of the American Medical Association.

In 38 percent of the cases, the alcohol-related problem was the main reason for admission, the researchers said. That group alone billed more than $335 million to Medicare, the taxpayer-financed health insurance plan that covers 96 percent of Americans who are 65 and older, the researchers reported.

A typical hospital stay cost $4,514, while 466 stays totaled more than $2,106,000, the study found.

Underestimating the Problem

In 1989, the national rate of alcohol-related hospital admissions was 48.2 per 10,000 among people 65 and older, the study found. The age group was second only to 45- to 65-year-olds in the rate at which they are hospitalized for alcohol-related reasons, the authors said, citing previous research that looked at all age groups.

"We have almost certainly underestimated alcohol-related problems in this population," the researchers said.

Hospitalizations for heart attacks, by comparison, range from as low as 16.9 per 10,000 people age 65 and older to as high as 44.1, depending on where people live, the report said, citing previous research that used the same rate-detection methods.

Rates of alcohol-related hospitalizations also had a wide geographical variation, generally reflecting the alcohol consumption rates across the overall population in that region, the researchers said.

"In general, the northern states had higher rates, and states in the central and southern Midwest had lowest rates," said the lead author, Dr. Wendy L. Adams of the Medical College of Wisconsin.

Alaska Leads in Alcoholism

Alaska had the highest rate, with 77 hospitalizations per 10,000 people 65 and older. Arkansas had the lowest, with 18.3 per 10,000, the researchers said.

Dr. Nancy J. Osgood, an alcoholism researcher and a professor of gerontology and sociology at Virginia Commonwealth University-Medical College of Virginia, said the study was well done.

"I think these findings are a lot more accurate than findings from other studies," she said in a telephone interview from Richmond. "Alcoholism in the elderly is much more hidden than in any other age group."

Conventional surveys may not accurately measure drinking among the elderly because they may not remember their drinking patterns as clearly as younger people, she said. Also, community-based surveys may use a certain amount of alcohol as a yardstick to gauge problem drinking, but it takes less alcohol to get an elderly person drunk, she said.
ALCOHOLISM AND THE ELDERLY

Alcoholism is the most serious drug problem among the elderly. It is estimated that at least 10 percent of the older population, about 3 million persons, have a serious alcohol problem, and for some groups the incidence is even higher.

Dramatic as these figures are, they underestimate the incidence of alcoholism among the elderly. Elder abusers drink more often, but in smaller quantities, than younger people. As they are less likely to be married or working, the problem is not as easily detected. Elderly drinkers hide their drinking problem, as do members of their families.

As a result of these and other factors, the problem of geriatric alcoholism is under recognized, under diagnosed, and under reported. As the 60+ population continues to increase at a rapid rate the problem of geriatric alcoholism will become an increasingly important issue. Compared to non drinking older adults, elderly alcoholics have higher rates of physical and mental illness, marital instability as well as reduced life expectancy. The effects of ingestion of large quantities of alcohol are more damaging in older individuals given their diminished physical and mental reserves.

The most prominent difficulties associated with alcohol abuse in the aged are: depression, decreased capacity of motor tasks, impairment in judgment, confusion, dementia, sleep pattern changes, anger, social isolation, accident proneness, decreased resistance to infections, and a host of other medical problems. There are numerous other effects, but these are the most common and the most easily identified.

There are two types of alcoholism in the elderly: the chronic alcoholic who has now become older, and the late onset type who has begun to drink as a reaction to a life stress, i.e., retirement, loss of a spouse, and/or illness. Both types respond to treatment, but the late onset type tends to be protected by friends and family.

The GAP, or Geriatric Alcoholism Treatment Program at Coney Island Hospital is a special program to treat alcoholism among the elderly. We have found that clients who are in treatment with others in the same age group, who have experienced many of the same losses, do amazingly well. With sobriety as the main focus, treatment includes involving the individual in socialization and group activities, involvement in twelve step recovery groups with other seniors, medical treatment of depression if necessary, and stress reduction.

This program has been in existence for one year and has experienced great success in treating elderly patients. If you wish further information contact Kevin Siewers, MSN, at Coney Island Hospital, 2601 Ocean Parkway, Brooklyn, N.Y. 11235, 718 615-5972.
The Cost of Alcohol-Related Traffic Crash Injuries

Alcohol is a factor in about one-half of all fatal traffic crashes and one-fifth of all crashes involving injury. As a result, a large portion of the economic costs of traffic crash injuries is attributed to crashes where alcohol is involved.

The 1985 cost of alcohol-related traffic injuries was about $15 billion.* This is the economic cost of injuries and death only—not including property damage. This cost of injury is the equivalent of $73 for every man, woman, and child in the entire U.S. population that year.** The $15 billion cost of alcohol-related traffic injuries for the Nation doubled the entire NASA budget for that year. Other comparisons of the magnitude of costs are provided in the chart on the left.

On an individual basis, each alcohol-related traffic death costs society approximately $330,000. Each non-fatal traffic injury costs a little less than $5,900.***

In 1991 drinking was a factor in over 17,000 fatal crashes and 197,000 injury crashes. For every age between 6 and 33, traffic crashes are the greatest single cause of death, and alcohol is involved in nearly half of these.

Another measure of the cost is the loss of person years of life. Traffic crash deaths generally involve victims who are much younger than those with diseases like cancer or heart disease, which are much more prevalent among the older part of our population. Each alcohol-related crash death costs our Nation an average of 37 years of a person's life. (By comparison an average cancer death costs 16 life years; heart disease, 12.) So the fatal, alcohol-related, traffic crashes in just a single year account for over 900,000 life years lost. By any standard, alcohol-related traffic crashes represent one of the most significant preventable cost to our Nation of any health problem.

*This is calculated by applying the 20% factor to the direct and morbidity costs and the 50% factor to the mortality costs provided by Rice et al., 1989. This is a quite conservative procedure since it assumes that the 20% factor is uniform over all crash injuries regardless of seriousness. However, the more serious the crash, the greater likelihood alcohol was involved.


***Calculated by using the Rice et al., 1989 data and applying the National Committee for Injury Prevention and Control, 1989 proportions.
Drinking Patterns in the Elderly

Today, 13% of the population in the United States is age 65 or older. By the year 2050, individuals over the age of 65 will account for 22% of the population in the United States. This anticipated growth clearly demonstrates an increasing need for health-related research focused on the elderly population.

Problem drinking among the elderly is a primary concern at the Research Institute on Alcoholism. It is important to conduct studies specific to this population because research has suggested that alcohol can affect the elderly differently than it affects the balance of the population. For example, the elderly may achieve the same effect with less alcohol. Also, alcohol may interact with medications and produce complications, as when it increases the stomach irritation from aspirin. Further, alcohol may compound age-related health problems such as high blood pressure. Lastly, it is critical to acknowledge that the aging process may mask symptoms of alcoholism.

Research has shown that heavy drinking and drinking related problems are uncommon among older Americans. Nevertheless, some elderly people maintain or increase heavy drinking patterns past the age of sixty. This phenomenon prompted Dr. John Welte and his colleagues at the Research Institute on Alcoholism to conduct a large-scale telephone survey to examine the factors which may encourage or cause it to occur.

A total of 2,400 individuals, age 60 years and older participated in the study. All participants were residents of an upstate New York county composed of city, rural, and suburban areas. The survey included questions regarding demographics, lifetime drinking patterns and problems, stress, coping resources and social supports. Of the first 1,658 individuals surveyed, 67% were female and 33% were male. The majority of the sample was white (94%), retired (65%) and had at least a high school diploma (73%). Of those surveyed, 59% were currently married, 30% widowed, 7% divorced and 4% had never been married. These demographics are representative of the county with the exception of whites and females, which are slightly overrepresented. This overrepresentation is characteristic of telephone surveys in general.

Certain stressful life events occur with greater frequency as a person ages. Retirement, illness and mourning are three examples. To deal with stress, individuals use different types of coping mechanisms. Some people, for example, deal with a problem by avoiding it; they pretend it never happened. Others may consider several alternatives for dealing with the problem, make a plan of action, and follow it. Additionally, individuals receive varying levels of social and emotional support when confronted with a stressful situation. This support may come from sources such as family, friends or colleagues. Hence, Dr. Welte examined the data to determine whether there was a relationship between stress, coping mechanisms and drinking among the elderly.

Analysis along these lines revealed no relationship between stress and drinking, regardless of the type of coping mechanism used by the individual. In other words, an elderly person is no more likely to drink heavily in response to a stressful life event if he deals with his problem by avoiding it than if he deals with it directly. The same is true for social and emotional support. The degree of social and emotional support an elderly person is given appears to have no bearing upon the amount of alcohol he consumes in response to a stressful life event.

Analysis of the data did show, however, that heavy drinking behaviors were typically established before age 60. At some time in their life, 12% of the sample were heavy drinkers (defined as more than four drinks per day; one drink = 1/2 oz. of pure alcohol). Yet only 1% of the sample were heavy drinkers during the past year (see figure 1). Correspondingly,
From these data, it is clear that late-onset problem drinking (heavy drinking after age 59) is not a very common occurrence. Nonetheless, because the elderly population is increasing at such a rapid rate, this phenomenon merits significant scientific attention. Hence, further research is necessary. Dr. Welte suggests that additional general population studies be conducted to assess lifetime drinking patterns as predictors of problem drinking in elderly populations.

(Reported by Judith M. Kemp, M.A.H.)

This Research in Brief is based on a project entitled "Etiology and Prevalence of Problem Drinking Patterns in the Elderly" supported by the Department of Health and Human Services Grant #90AR0022, awarded to J. Welte, Ph.D. For additional information on this study, please contact Dr. Welte at the Research Institute on Alcoholism.

All data are based on the first 1,658 individuals surveyed.

Respondents were asked questions regarding their drinking behavior around the time they were 20 years old, around the time they were 40 years old, and at the time in their lives when they were drinking the most.
Ideas

The Ideas column features brief notes about interesting or unusual programs, novel approaches to therapy, and useful resources in the mental health field. Contributions to Ideas are welcomed. Items, not exceeding 200 words, should be sent to the Editor, Ideas, Hospital and Community Psychiatry, 1400 K Street, N.W., Washington, D.C. 20005.

Psychoeducational Training for Mental Health Workers

Many staff members who have the most intensive contact with patients in hospital and community settings are untrained or undertrained in psychiatry. These staff—be they mental health workers, nursing assistants, counselors, foster care providers, or case managers—can benefit from a structured psychoeducational program similar to those that have helped families understand and cope with the needs of chronic mentally ill relatives.

Such a training program for frontline mental health staff is now available through the National Center for Human Development at Sheppard and Enoch Pratt Hospital in Baltimore. The training includes an in-depth review of mental illness symptoms and their variations and an overview of current theories about psychiatric disorders and major treatment interventions. In addition, communication techniques and strategies are practiced through role playing and small group exercises. (Nancy Alexander, L.C.S.W., A.C.S.W., Sheppard and Enoch Pratt Hospital, 6501 North Charles Street, Baltimore, Maryland 21283)

Mental Health Outreach in a Transportation Program for the Elderly

The Positive Aging Service of the Massachusetts Mental Health Center in Boston offers a wide range of mental health outreach, one component of which is a transportation program for elderly persons with physical and psychological disabilities. The drivers are trained in basic outreach principles, first aid, and cardiopulmonary resuscitation and in how to recognize mental illnesses of late life. Funds for staff salaries come from the State Department of Mental Health, and federal and local grants and private contributions have paid for the service's vans and their operating costs. In 1989, a total of 4,212 round trips were provided to 90 different persons, of whom 13 were identified as being in need of additional mental health services. (Bennett Gurai, M.D., Massachusetts Mental Health Center, 74 Fenwood Road, Boston, Massachusetts 02115)

Referral Practices and Patients' Follow-Up

The effect of a variety of patient and agency characteristics on patients' appearance for follow-up appointments after referral from a psychiatric walk-in service was studied at a Veterans Affairs outpatient clinic in Boston. A total of 160 patients were referred for further treatment to the clinic's mental hygiene unit during the five-month study period; most were white men, and nearly half did not identify themselves with any occupation.

Of the 160 patients, 124 returned within a month for their initial appointment. No significant relationship was found between patient characteristics and follow-through, but the agency's referral procedures had an effect. Patients who were given a scheduled appointment rather than a simple referral, patients who were contacted by phone about their assignment to a clinician, and patients who were given an appointment with the same clinician they saw at the walk-in service were more likely to return for further treatment. (Ann McCarthy Carroll, M.S.W., L.I.C.S.W., Arboretum Hospital, 49 Robinwood Avenue, Jamaica Plain, Massachusetts 02130)

Case Management for Mentally Ill Veterans

A pilot clinical case management project instituted by the social work service at the Veterans Affairs Medical Center in Togus, Maine, uses an outreach approach and a treatment model combining supportive therapy and traditional social services to improve the quality of life for chronic mentally ill veterans living in the community. A master's-level social worker visits 39 veterans. Individual treatment plans include enhancing patients' ability to cope with their illness, increasing knowledge about and compliance with medication regimes, reducing stress, and improving communication skills. The project has a rigorous evaluation component in which the cost-effectiveness of the clinical case management approach is being compared with traditional aftercare offered by the VA medical center. (Joseph P. Francione, M.S.W., L.C.S.W., William B. Stason, M.D., and Cecil Munson, A.C.S.W., Veterans Affairs Medical Center, Togus, Maine 04330)
Chapter 5

Substance Abuse Problems of the Elderly: Considerations for Treatment and Prevention

Ann W. Lawson

INTRODUCTION

The geriatric population is often overlooked and sometimes hidden in American society. Yet it is a rapidly growing population with increasing needs. Of the estimated 250 million people in the United States, 20 million are older than 65. It is predicted that 35 million people will be in this age bracket by 1990. Offer (1974) predicted that by the year 2000, one half of the population will be older than 50 and one third will be older than 65. Brotman (1980) reported that life expectancy for men is 70 and for women is 77. With advances in technology and medical care, these estimates may rise even higher, and the life expectancy could increase. Even though the elderly population is increasing, their problems continue to be overlooked or misdiagnosed.

Although it may seem that the elderly have more physical problems than other populations, they are rarely thought of as drug abusers. Yet the elderly are at high risk for misuse and at considerable risk for abuse of legal drugs, and there is a small group of elderly opiate addicts (Glantz, 1983). These misuses and abuses include alcohol, prescription drugs, and over-the-counter drugs. These problems are often complicated by mental disorders or are confused with the symptoms of aging. Furthermore, the elderly use 3 times as many prescription drugs as all other groups combined (Hanan, 1978). This puts them at risk for drug interactions that often go undiagnosed because of the similarity between drug interaction symptoms and the symptoms of old age (forgetfulness, weakness, confusion, tremor, anorexia, and anxiety).
PHYSICAL, SOCIAL, AND PSYCHOLOGICAL RISKS FOR SUBSTANCE ABUSE

The aging process creates new physical, social, and psychological stresses that increase the risk level of drug abuse and misuse for the elderly. Physical aging processes promote a dependence on drug use for symptom reduction that can lead to overmedication and drug misuse. The physical changes of aging alter the way in which a drug is absorbed and distributed through the body, metabolized, and then excreted. The elderly experience decreased tolerance for drugs, and drugs stay in the body longer and have prolonged biological activity. They have more clinical and toxic effects, and they tend to accumulate in fatty tissues (Shader, 1975). Additionally, the elderly have increased physical illnesses and complaints, some from the physical aging process and some from psychosomatic origins. They have more contact with physicians who prescribe medications, and they may be less concerned with the prevention of illness and more concerned with medication of symptoms. They are often victims of self-neglect, falls, and aggressive and violent behavior, sometimes at the hands of their relatives.

Loss also plays a part in physical risk; the loss of body functions and attractiveness is a problem for some of the elderly. They may lose teeth and hair, develop dry skin, and lose muscle tone. The senses are also affected. Vision and hearing losses can lead to reduced communication or misunderstandings that create paranoid ideas. Ultimately, these physical limitations may reduce the availability of hobbies and sports that provided identity and self-worth.

Psychologically, the elderly face a number of late-life stresses including bereavement from the loss of family and friends, loss of occupation because of retirement, loneliness, boredom, and impaired health and physical abilities. Many of these losses occur within short periods of time. Stresses mount one upon the other, and the elderly can find themselves constantly dealing with loss. Kinney and Leaton (1987) reported that the elderly can react to these losses in several ways. They commonly use denial to avoid facing the reality of the losses. They may pretend that the problems do not exist or are just temporary. The emotional pain may be expressed by somatization, or complaining of physical pain that is an outward expression of hurt from the loss. This may be seen as socially more acceptable, and it may be reinforced with attention from medical personnel, whereas emotional problems may be ignored. If the elderly respond to the losses by restricting their emotional responses, they may begin to withdraw from their environment in an attempt to shut out further “bad news.” Unfortunately, this creates more of a problem with depression and lack of support systems.

Substance Abuse

- Depression is prevalent among older people caused or a manifestation of a problem in the elderly population who commit suicide are over age 65. The five times that of the general population's times higher” (Kinney & Leaton, 1987, p).

Sociologically, loss plays a part in increasing the elderly. With aging come the ill-fated friends. Isolation becomes more of a problem, and deaths also bring about thoughts of one's considerable anxiety. Geographical separation of the family. Children leave home for school away. The grandchildren that should be the elderly's close have only once or twice.

Retirement changes the social environment. The loss of income affects the elderly by fixing income, and often reducing common financial losses are the losses of status, identity. Even the gain of spending more time with the family without adjusting to the change of routines and person's needs.

- The sex life of the elderly is often affected. If the elderly are physically healthy, there is sexual activity and are physically capable of being a partner and society's being sexually active. Rarely are the elderly's activity may be discouraged even in marriage. Considering the difficulties of aging. Now they could be at risk for drug abuse and changes of aging, the elderly's abuse that attempts to relieve this pain. By the need for medications and the futility of this profession.

It is interesting to compare this age group that is more easily recognizable include uncertain and changing roles and disadvantages in employment and income support, and limited resources for readily available. One difference is that often, whereas the elderly use illicit drugs, understandable for people who grew colored their views of alcohol consumption.
PSYCHOLOGICAL RISKS FOR

Physical, social, and psychological stresses and misuse of drugs for the elderly. Physical experience can lead to drug use for symptom reduction and drug misuse. The physical changes drug is absorbed and distributed throughout the body. The elderly experience drug stay in the body longer and have more clinical and toxic effects, especially on the liver (Shader, 1975). Additionally, physical illnesses and complaints, some from emotional origins. They have no prescribe medications, and they may consider themselves to be victims of self-neglect, fail, and sometimes at the hands of others. Physical risk; the loss of body functions and some of the elderly. They may lose teeth and muscle tone. The senses are also less acute. Reduced communication or paranoid ideas. Ultimately, these physical and emotional habits and sports that provided a number of late-life stresses including family and friends, loss of occupation because of age, and impaired health and physical ability within short periods of time. Stresses the elderly can find themselves constantly eaten (1987) reported that the elderly can ways. They commonly use denial to avoid being isolated. They may pretend that the problems do not exist. The emotional pain may be expressed by physical pain that is an outward expression of being socially more acceptable, and if from medical personnel, whereas emotions. If the elderly respond to the losses by stress, they may begin to withdraw from it to shut out further "bad news." Unfor-

Depression is prevalent among older people. It may be environmentally or physically caused or a manifestation of a physical problem. Suicide is also a problem in the elderly population. "Twenty-five percent of those who commit suicide are over age 65. The rate of suicide for those over 65 is five times that of the general population. After age 75, the rate is eight times higher" (Kinney & Leaton, 1987, p. 306).

Sociologically, loss plays a part in increasing the risk of substance abuse for the elderly. With aging come the illnesses and deaths of family and friends. Isolation becomes more of a problem to those left surviving. These deaths also bring about thoughts of one's own death, which can cause considerable anxiety. Geographical separations are also a part of the family life span. Children leave home for school and marriage and often move far away. The grandchildren that should provide comfort and stimulation to the elderly may visit only once or twice a year.

Retirement changes the social environment of the elderly in many ways. The loss of income affects the elderly by decreasing purchasing power, fixing income, and often, reducing comfort and luxury. Along with the financial losses are the losses of status, identity, and sometimes self-worth. Even the gain of spending more time with spouses can become a problem: adjusting to the change of routines and making allowances for the other person's needs.

The sex life of the elderly is often affected, not physically but sociologically. If the elderly are physically healthy, they are usually interested in sexual activity and are physically capable. The biggest problems lie in the availability of a partner and society's belief that the elderly should not be sexually active. Rarely are the elderly encouraged to date, and sexual activity may be discouraged even in married couples.

Considering the difficulties of aging, it becomes more understandable how they could be at risk for drug abuse. If self-esteem is reduced by the losses and changes of aging, the elderly are at risk for drug and alcohol abuse that attempts to relieve this pain. This risk can be further increased by the need for medications and the frequent contacts with the medical profession.

It is interesting to compare this aging population with adolescents, an age group that is more easily recognizable as drug abusers. The similarities include uncertain and changing roles and self-concepts, lower social status, disadvantages in employment and income, shifting and uncertain social supports, and limited resources for coping. Both groups also find drugs readily available. One difference is that adolescents use illicit drugs more often, whereas the elderly use licit drugs (Mandolini, 1981). This difference is understandable for people who grew up in the Prohibition era, which colored their views of alcohol consumption and the use of illegal substances.
This same group spent a lifetime learning to trust physicians and to use medications when they were sick. Often, their physician is an important social contact who gives them drugs to relieve symptoms and stresses.

Drugs most often prescribed for elderly patients are cardiovascular medication (22%), tranquilizers (10%), diuretics (9%), and sedative-hypnotics (9%) (Mandolini, 1981). These drugs are prescribed for heart disease, hypertension, arthritis and rheumatism, and mental and nervous conditions. It is common for the elderly to combine their prescription drugs with over-the-counter drugs, increasing the potential for harmful interactions.

In addition to prescription drug misuse, the elderly may engage in alcohol problems, psychiatric disorders, and reduced resources. These difficulties are hard to diagnose, and they overlap. The elderly may not seek psychological care or drug and alcohol rehabilitation, and they may have lost many of the social contacts who could intervene and get help for them: the threat of job loss is no longer there, and they may be living alone with little contact with family and friends. To complicate the picture further, the elderly may be experiencing new physical limitations. Busse (1983) pointed out that two in five men aged 65 and over have restricted activity, and one in four is unable to carry on some major activity. Those over 75 years of age are even more limited.

This chapter focuses specifically on drug misuse and abuse, alcohol problems, and the best methods of helping the geriatric client. There is limited literature on the problems of the elderly and the kinds of therapy most beneficial to them. As Glantz (1983) noted, “Research in this area is really just beginning and the relevant literature is limited, often inconclusive and sometimes contradictory” (p. 1). It is, however, important for therapists to be aware of potential problems and the symptoms of these problems in their elderly clients.

ABUSE AND MISUSE OF LEGAL DRUGS

Because of their physical problems and reliance on the medical profession, the elderly are at risk for overmedication by their physician, drug interactions, erratic drug use, and misuse of over-the-counter drugs (Whittington, 1983b). Their unique life situations and the presence of chronic illnesses contribute to the misuse. The aging who are most at risk are alcoholics, the chronically painfully ill, and those who are troubled with chronic anxiety states, somatization disorders, and insomnia (Kofod, 1985).

How common is substance abuse in late life? Use of illegal drugs such as marijuana, LSD, and opiates is usually found only in aging criminals.
Older opiate users often switch to more readily available drugs such as hydromorphone (Dilaudid) and reduce their intake, or they use barbiturates or alcohol as substitutes on occasion. The abuse of cocaine and amphetamines is rare mainly because of the decreased effect of these drugs with aging and changing neurochemistry (Kofoed, 1985). Although this is a small problem with the elderly now, as the younger population currently abusing illicit drugs grows older, it will probably increase.

More frequently, the elderly abuse prescription drugs. They comprise 10% of the population, yet they use 25% of all prescribed drugs (Basen, 1977). Prescription drugs are more available than illicit drugs to the elderly and are often prescribed for pain or insomnia. Sedatives and narcotics are the most common drugs of abuse, followed by narcotic analgesics (Kofoed, 1985). Women, twice as often as men, abuse analgesics (including opioids), antianxiety agents, and sedative hypnotics (Atkinson, 1984). Twenty-five percent of the drugs prescribed for the elderly are psychoactive. Stephens, Haney, and Underwood (1982) found that 18% of the elderly receive psychoactive drugs. However, two thirds were taking them as prescribed; those who were not were underusing them. The major problem with prescription use among the elderly is omission (Schwartz, Wang, Zweitz, & Gross, 1962). This can be as much of a problem as overmedication. Medications taken properly can improve the quality of life for the elderly and may be needed to allow independent living.

It is important to distinguish between drug abuse and misuse with the elderly: this distinction helps to locate the area in which intervention is needed. There are two major differences between abuse and misuse. First, abuse is intended, or the inappropriateness of use is known, whereas misuse is inadvertent. Second, abuse has psychoactive or psychosocial consequences and may involve licit or illicit drugs, including alcohol (Glantz, 1983), whereas misuse does not.

To elucidate further, drug abuse is the nontherapeutic use of drugs, including alcohol, that adversely impacts the user’s life. The drug may be obtained from legal or illegal sources and used occasionally or habitually. As Glantz (1983) outlined, abuse entails some or all of the following:

- using an illegal drug
- using an illegally obtained drug (i.e., by falsified prescription)
- using multiple prescriptions of the same or similar drug
- using a drug prescribed for another person
- hoarding drugs and taking them all at one time
- knowingly using a drug for purposes other than those for which it was prescribed
Physicians may hold stereotypes of the elderly. This may cause physicians to the nonmedical problems. This process is allowing problems of the elderly (Whittin

- They may have several simultaneous
- They experience a slower rate of metabolism, and excretion.
- They are at greater risk for side effects.
- They often have cognitive deficits. Powerless authorities whom they will

Given this dilemma, it is difficult to physicians need to be educated about the psychological needs of the elderly, or do they? The answer, probably, is both, but the physicians can also be teachers and advocates that are inherent when a such a patient.

Several investigators have studied the the elderly to determine the reasons in Florida. When questioned about the process of said they did not usually inform physicians 13% saw the physician in person, and over the telephone. Furthermore, 75% about the drug's action, possible side effects of the patient's medication and the potential for side effects or interaction. Stephens, Haney, and Underwood stopped their medication or varied it like it" (or possibly did not like the phone when they needed it). 6.8% said that the experienced bad side effects, 9.4% felt 2.7% forgot. Although all is reported high esteem, they often appear to make are often against the physician's advi
Physicians may hold stereotypes of the elderly. They may feel that aging is synonymous with disease and that there is little that can be done to help the elderly. This may cause physicians to rely on medical (drug) solutions to nonmedical problems. This process is further complicated by the following problems of the elderly (Whittington, 1983a):

- They may have several simultaneous problems and medications.
- They experience a slower rate of drug absorption, distribution, metabolism, and excretion.
- They are at greater risk for side effects.
- They often have cognitive deficits and may view their physician as a powerful authority whom they will not question.

Given this dilemma, it is difficult to know where to intervene. Do physicians need to be educated about the unique pharmacological and psychological needs of the elderly, or do the elderly need to be self-advocates? The answer, probably, is both, but therapists who work with elderly patients can also be teachers and advocates once they understand the risks that are inherent when a such a patient seeks medical help.

Several investigators have studied the misuse of prescription drugs among the elderly to determine the reasons for the problem. Doyle and Hamm (1976) studied 405 people in Florida who were 60 years of age or over. When questioned about the process of receiving prescription drugs, 72% said they did not usually inform physicians if they were using drugs; only 13% saw the physician in person, and the rest received the prescription over the telephone. Furthermore, 75% did not question the pharmacist about the drug's action, possible side effects, or its cost. The Michigan Office of Services to the Aging and Michigan Office of Substance Abuse Services (1979) surveyed 371 persons aged 60 or older to discover why they stopped taking or varied their prescription drugs. The responses indicated that 43% felt better when they stopped or varied their prescription drugs, 18% reported side effects as the reason, and 10% forgot to take the medication. Stephens, Haney, and Underwood (1981) found that their subjects stopped their medication or varied it for several reasons: 48% "did not like it" (or possibly did not like the physician), 23% used medication only when they needed it, 6.8% said that they got better results their way, 4.1% experienced bad side effects, 9.4% felt the drug was too expensive, and 2.7% forgot. Although it is reported that the elderly hold physicians in high esteem, they often appear to make medical decisions themselves that are often against the physician's advice.
Another area of prescription drug misuse is institutions. Often there is overuse of psychoactive medication, particularly sedatives and tranquilizers, because of the staff's desire to control agitated, unruly, or demanding patients (Gubrium, 1975; Learoyd, 1972). Misuse can include errors in the administration of drugs in nursing homes (too much, too late, or with the wrong liquid); this is due to a lack of staff training, poor controls, overloa
ded staff, and the use of unlicensed nursing aides to distribute medica
tions (Gubrium, 1975).

The main reason that abuse and misuse of prescription drugs by the elderly and those attending them are dangerous is their unique biological changes that cause the elderly to react differently than younger adults. With aging comes a decline of protein and an increase in fat. Moreover, the metabolic rate declines 16% between 30 and 70 years of age, and caloric requirements decrease by one third. The loss of brain cells may also make the elderly more sensitive to drugs, and enzymes and neurotransmitters are altered. The activity of monoamine oxidase increases, and dopamine, norepinephrine, serotonin, tyrosine hydroxylase, and cholinesterase activi
ties decline. Furthermore, absorption of drugs is slow and erratic because of the low acid level in the stomach. Fat-soluble drugs (phenobarbital, diazepam, and chlorpromazine) tend to be stored for longer periods in the elderly. For these reasons there is a decrease in the intensity of the drug but a prolonged duration, which ultimately produces a toxic effect. Circula
tory changes also alter drug absorption; drugs may accumulate in the brain and heart because the organs are the first to be supplied in the presence of a decreased cardiac output. The liver's capacity to metabolize drugs decreases with aging; this may be due to a reduced protein intake, which reduces available metabolizing enzymes, and may cause prolonged effects of some drugs. Other drugs that need to be metabolized for full effect are reduced in their effectiveness (Hanan, 1978). The kidneys also lose their functioning: there is a 30% glomerular filtration rate in individuals older than 65 so that drugs are excreted less efficiently.

Because of the potential for misuse of prescription drugs by the elderly, the therapist working with this population should be alert to signs of psychological reactions and behavior changes that could be due to toxicity or drug interaction. Antipsychotic drugs may cause oversedation, restlessness, withdrawal, and depression. Antidepressants may elicit confused states and exacerbate schizophrenic and manic symptoms. Antianxiety drugs may lead to oversedation and occasionally disinhibition or uncontrolled rages. Antimanic drugs such as lithium can cause confused states that can mimic organic brain syndrome if the drug level becomes toxic. This distinction is particularly crucial.

Substance Abuse

ABUSE AND MISUSE OF OVER-THE-COUNTER MEDICATIONS

One of the most dangerous practices among the elderly is self-medicating with over-the-counter medications. In the United States, 69% of people 60 years of age and older use drugs daily. This is due to a lack of knowledge about the effects of these drugs, and the idea that they are safe to take. Over-the-counter drugs can cause many problems, so it is important to work with these clients.

In large doses, analgesics such as aspirin can cause toxic metabolic disturbances and organ failure. Acetaminophen and代码, levels, and overdoses can cause liver damage. Antacids are used by elderly patients for diarrhea and malabsorption syndromes. These drugs, which include cold and allergy medicines, with alcohol and other drugs to enhance the effects. A study of elderly patients found that they had alcohol-related problems and were at risk for developing toxic psychosis or delirium from alcohol in combination with other drugs. In one study, 40% of elderly patients were found to be using alcohol with other drugs, which increased the risk of toxic psychosis.

Although caffeine and nicotine may be in common daily use, they can also be problematic. Caffeine can contribute to anxiety and agitation, while nicotine can contribute to smoking-related diseases, such as lung cancer. Over-the-counter medications as well as herbal remedies, such as echinacea, can interact with each other and with prescription drugs, leading to unwanted side effects. A study of community-dwelling elderly patients found that 70% of elderly patients were using prescription drugs and over-the-counter medications, which increased the risk of interactions and side effects.

ALCOHOL ABUSE AND ALCOHOLISM IN THE ELDERLY

Research has indicated that alcohol abuse is common in the elderly. An estimated 2% to 10% of the elderly population have alcohol use disorders, which can be difficult to diagnose. The symptoms of alcohol use disorders can be different in the elderly, and may include withdrawal symptoms, confusion, and memory problems. A study of elderly patients found that 70% of patients with alcohol use disorders were not diagnosed, which can lead to missed opportunities for treatment.

In conclusion, the elderly population is at risk for misuse of prescription drugs and self-medicating with over-the-counter drugs. It is important to work with these clients and be aware of the potential dangers of these drugs. Treatment options are available, and with proper treatment, the elderly population can improve their quality of life and reduce the risk of complications from drug misuse.
ABUSE IN SPECIAL POPULATIONS

ABUSE AND MISUSE OF OVER-THE-COUNTER DRUGS

One of the most dangerous practices among the elderly is self-diagnosing and self-medicating with over-the-counter drugs. Kofod (1984) reported that 69% of people 60 years of age and older use such drugs, and 40% use them daily. This is due partly to economics and possibly to bad experiences with health professionals. Over-the-counter medications can cause the elderly many problems, so it is important to screen for them routinely when working with these clients.

In large doses, analgesics such as aspirin and acetaminophen can cause acute metabolic disturbances and organic mental disorders. Aspirin can cause stomach bleeding. Acetomenophen elevates serum alkaline phosphatase levels, and overdoses can cause liver damage (Stewart, Hale, & Marks, 1982). Laxatives are used by 10% of the elderly and can cause diarrhea and malabsorption syndromes. Antihistamines and anticholinergics, which include cold and allergy medications and sleeping aids, interact with alcohol and other drugs to enhance sedative effects. It is possible to develop toxic psychosis or delirium from anticholinergics. Antihistamines may be used by the elderly as sedatives and can produce acute toxic delirium resembling atropine psychosis (Shader, 1975). Sympathomimetics or decongestants can have a stimulant effect and produce psychoses similar to those induced by amphetamines, although this is rare in older persons. Alcohol-containing drugs, such as night cold medicines, are often used for the alcohol effect, but some elderly consider them medicine and deny that they have alcohol related problems. Antacids and bromides have been known to cause psychiatric symptoms; bromide toxicity can resemble schizophrenia.

Although caffeine and nicotine may not seem dangerous because they are in common daily use, they can be problematic for the elderly. Caffeine overuse can contribute to anxiety and panic disorders, cardiac dysrhythmias, gastric disease, and osteoporosis. Caffeine is often found in over-the-counter medications as well as in beverages. Nicotine contributes to oral and lung cancer, osteoporosis, weight loss, decreased muscle strength, and decline in pulmonary functions. Heavy cigarette use in older men may indicate high alcohol consumption and should be investigated (Schuckit & Miller, 1976).

ALCOHOL ABUSE AND ALCOHOLISM

Research has indicated that alcohol abuse and alcoholism do exist among the elderly. An estimated 2% to 10% of the elderly suffer from alcoholism
(Glantz, 1983). The subgroup with the highest risk is widowers over age 65 (Kinney & Leaton, 1987). There is a higher than average incidence in widows, nursing home residents, patients on medical wards, and psychiatric patients (Schuckit & Miller, 1976; Zimberg, 1979).

Three factors contribute to the reported low rate of alcoholism among the elderly: (a) the early mortality of alcoholics; (b) "spontaneous recovery" attributed to substitute dependencies (67%), medical problems induced by alcohol (48%), membership in Alcoholics Anonymous (AA) (38%), or a new love relationship (38%); and (c) underdiagnosis and underreporting (Vaillant & Milofsky, 1982). Alcoholism among the elderly is often hidden by family members or through isolation, or it is sometimes confused with normal aging, because trembling, confusion, and mental lapses can be seen as symptoms of alcohol abuse and dependency or aging.

Elderly alcoholics differ from younger alcoholics in several ways. They do not drink as much on each occasion, but they are likely to drink more frequently. They rarely reach the point of needing detoxification and rarely have withdrawal symptoms (National Institute on Alcohol Abuse and Alcoholism, 1978). They may be more psychologically dependent than physically dependent on alcohol.

Investigators have distinguished two types of elderly alcoholics: early-onset and late onset (Zimberg, 1974a). Approximately two thirds of the elderly alcoholics are early onset, and one third are late onset. The early onset alcoholics are those who began to have drinking problems early in life and have survived into old age. They may or may not have developed physical problems as a result of their drinking, and they may have personality characteristics similar to those of younger alcoholics.

Late onset alcoholics have recently begun to experience alcohol problems, usually in response to stress in their lives. They do not have the personality characteristics of younger alcoholics, but they do experience the stresses and problems of aging: depression, bereavement, loneliness, retirement, marital stress, and physical difficulties (Rosin & Glatt, 1971). Most late onset alcoholics begin drinking in an attempt to alleviate life stresses; the behavior is therefore seen as reactive. Because the alcohol enhances the feelings of isolation and boredom that led to the drinking in the first place, a destructive cycle of more isolation and more alcohol to relieve it becomes established. Late onset alcoholics are generally responsive to treatment and have a good prognosis, but they often go unnoticed and untreated. In a study conducted in Baltimore, Rathbone-McCuan, Lohn, Levenson, and Hsu (1976) found that 85% of those who could be diagnosed as alcoholic were not receiving treatment for their alcohol problem.

Although many of the alcohol problems are hidden, older people who drink excessively of younger alcoholics, including hallucinations, psychological dependence, and existing health problems being exacerbated, family and marriage problems, with job-related problems (if they are still legal problems (Carruth, 1973).

In a study of lifetime drinking patterns of the elderly, Dunham (1980) found that 100 of those interviewed reported drinking. Subjects were placed in five drinking patterns: light drinkers, infrequent drinkers, infrequent drinking throughout life (21%), light drinking (11%), and highly variable (8%).

In the rise and fall pattern, the subage 21, increased at age 24, was heavy and terminated (complete abstention) women with low levels of education. In the rise and sustained pattern, the subage 17, increased at age 25, and were usually white or black men without the least likely to have alcohol relate throughout their lives began at 30 at about age 72. These subjects were usually high school education; they had illnesses. Subjects who reported high consumption began at age 31 and started were usually Latin men with a low in the late starter pattern, subjects began for 17 years or began at age 49 and these subjects were mostly black or dropped early were mostly women. The rate. Those characterized as variables; their drinking at age 30, crossed the first peak after 9.6 years. The subjects were usually black men. Dunham (1981) pointed out that a can be problematic for the elderly.
ABUSE IN SPECIAL POPULATIONS

Although many of the alcohol problems of the elderly are stress related or hidden, older people who drink experience problems similar to those of younger alcoholics, including hangovers, blackouts, memory loss, shakes, psychological dependence, health problems and accidents due to existing health problems being exacerbated by alcohol use, financial problems, family and marriage problems, problems with friends and neighbors, job related problems (if they are still employed), attitude problems, and legal problems (Carruth, 1973).

In a study of lifetime drinking patterns aimed at elucidating the drinking patterns of the elderly, Dunham (1981) interviewed 310 persons 60 years of age or older living in low income housing in Dade County, Florida. Only 100 of those interviewed reported any drinking in their lifetime. Subjects were placed in five drinking categories: heavy drinkers, moderate drinkers, light drinkers, infrequent drinkers, or abstainers. Six life patterns were discovered: rise and fall (25%), rise and sustained (28%), light drinking throughout life (21%), light drinking with late rise (7%), late starters (11%), and highly variable (8%).

In the rise and fall pattern, the subjects' alcohol consumption began at age 21, increased at age 24, was heavy for 17 years, decreased at age 61, and terminated (complete abstinence) at age 68. These subjects usually were women with low levels of education and an alcohol related illness. In the rise and sustained pattern, the subject's alcohol consumption began at age 17, increased at age 25, and was heavy for 36 years. The subjects were usually white or black men with average education, and they were the least likely to have alcohol related illnesses. Those who drank lightly throughout their lives began at 30 and usually returned to abstinence at about age 72. These subjects were most often Latin women with less than a high school education; they had a moderate chance of alcohol related illnesses. Subjects who reported light drinking with a late rise in alcohol consumption began at age 31 and started drinking heavily at age 74; these were usually Latin men with a low incidence of alcohol related illness. In the late starter pattern, subjects began drinking at age 54 and continued for 17 years or began at age 49 and continued for 3 years and stopped. These subjects were mostly black or white (not Latin) men; those who stopped early were mostly women. The alcohol related illnesses were moderate. Those characterized as variable drinkers began at age 22, increased their drinking at age 30, crossed the light-moderate boundary 3 times, reached the first peak after 9.6 years, and decreased at ages 56 and 65. The subjects were usually black men with alcohol related illnesses.

Dunham (1981) pointed out that at least four of these drinking patterns can be problematic for the elderly: rise and sustained, light drinking with
late rise, late starter, and variable patterns. Findings also indicated that women are likely to return to abstinence, whereas men often continue heavy drinking. Blacks often follow variable patterns and have many alcohol-related illnesses, and whites most often follow the rise and sustained pattern. People following these two patterns are most likely to become early onset alcoholics, while those who follow the light drinking with late rise or the late starter pattern are apt to become late onset drinkers. This information may be useful to the therapist when obtaining drinking and drug use histories from patients; it helps identify those who are in high-risk groups and indicates treatment strategies.

There are additional risk factors for elderly alcoholics. Family and genetic factors play a part: there is an inverse relation between reported family alcoholism and the age of onset of alcoholism (Atkinson, 1984). Older alcoholics in treatment have a lower rate of family alcoholism than younger patients (Jones, 1972; Penick, Read, Crowley, & Powell, 1978). This is probably due to a complication of environmental factors in alcoholic families that produces early alcohol abuse among children of alcoholics. Late onset alcoholics (after age 40) report familial alcoholism 41% of the time, and early onset alcoholics report a family influence in 86% of the cases (Atkinson, 1984). This underscores the role of late-life stresses and adjustments as a risk factor for late onset alcoholism. Not all stressed elderly people become alcohol abusers late in life, however, and stress may not be a factor in early onset alcoholism.

One of the most dangerous problems for the elderly who drink is the interaction of alcohol and other drugs. As discussed earlier, the elderly use many prescription and over-the-counter drugs that can cause problems when combined with alcohol. States of confusion or sedation out of expected proportions can occur: “Unexpected response to prescribed medication may be the clinician’s first clue to undisclosed substance abuse” (Atkinson, 1984, p. 12).

Because environmental stresses and psychological reactions to aging play an important part in the etiology of substance abuse in the elderly, they respond well to treatment that considers alleviating some of the environment problems. Therapies that have been helpful with the elderly substance abuser are socialization, group therapy, case work, and cognitive therapy. Zimberg (1974b) recommended psychosocial interventions with the elderly. Antidepressant medications are sometimes necessary, but often cognitive therapy is more effective. Elderly alcoholics view their alcoholism differently than younger alcoholics; they feel that they do not need detoxification and are reluctant to undergo inpatient treatment. They may also feel out of place if they are admitted to a program with younger alcoholics. Feelings of stigma are greater among the elderly, probably because they grew up before and during the 1 known, mentioned, or done about people were conditioned to feel guilty a result they use a strong denial sys- (Salman, 1984).

TREATMENT OF THE ELDERLY

The elderly are underrepresented in seek assistance from traditional treat to ask for help. Therapists may be relu they think the treatment will be unsu their lives, or they lack hope for the wards may be reluctant to treat the el lems that put them at high risk for it Cardiovascular impairments in the el Aversive therapies, such as shock or also not recommended. Lack of hosp erly patients out of treatment center reject older people because they fear ge help, they respond well.

The elderly need to be treated in pl Senior citizen centers in neighborh people are good places to work with th are helpful. Efforts can be made to who specialize in geriatric populatio substance abuse. Many elderly citizens visits are a good way to see the eld This helps with evaluation provides information about family a Therapists who want to work wit liking of old people. They must hav of caring for the elderly; a history of an ability and desire to learn from of life can be challenging and fruiti chological and social needs of the el own eventual old age; an understand period of life, an ability to deal with lessness, grief, hostility, and despa mor, patience, enthusiasm, courage nondelensiveness, freedom from im
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chological reactions to aging play substance abuse in the elderly, they alleviating some of the environ-helpful with the elderly substance use work, and cognitive therapy, social interventions with the el-sometimes necessary, but often alcoholics view their alcoholism feel that they do not need detox-patient treatment. They may also program with younger alcoholics. the elderly, probably because they grew up before and during the Prohibition era, when little was known, mentioned, or done about drinking problems. These same people were conditioned to feel guilty and ashamed when they drank. As a result they use a strong denial system to hide their drinking (Buys & Saltman, 1984).

TREATMENT OF THE ELDERLY

The elderly are underrepresented in treatment populations. They do not seek assistance from traditional treatment sites and are often embarrassed to ask for help. Therapists may be reluctant to treat elderly clients because they think the treatment will be unsuccessful in making major changes in their lives, or they lack hope for the future of the elderly. Inpatient alcohol wards may be reluctant to treat the elderly because of other physical problems that put them at high risk for injury with some treatment methods. Cardiovascular impairments in the elderly make it risky to use Antabuse. Aversive therapies, such as shock or nausea-producing medications, are also not recommended. Lack of hospitalization insurance keeps some el-derly patients out of treatment centers, and some detoxification centers reject older people because they fear medical dangers. Yet when the elderly get help, they respond well.

The elderly need to be treated in places that they are already frequenting. Senior citizen centers in neighborhoods with a high population of older people are good places to work with the elderly. AA groups in these centers are helpful. Efforts can be made to combine the expertise of the therapists who specialize in geriatric populations and those who specialize in substance abuse. Many elderly citizens may need help in their homes. Home visits are a good way to see the elderly person in his or her safest environment. This helps with evaluation of his or her level of functioning and provides information about family and home life.

Therapists who want to work with the elderly need more than just a liking of old people. They must have a genuine respect and a deep sense of caring for the elderly; a history of positive experiences with the elderly; an ability and desire to learn from them; a conviction that the last years of life can be challenging and fruitful; knowledge of the biological, psychological and social needs of the elderly; a healthy attitude regarding their own eventual old age; an understanding of the developmental tasks of each period of life; an ability to deal with extreme feelings of depression, hopelessness, grief, hostility, and despair; personal characteristics such as humor, patience, enthusiasm, courage, endurance, hopefulness, tolerance, nondefensiveness, freedom from limiting prejudices, and a willingness to
learn; and the ability to be both supportive and challenging and the sensitivity to know when each is needed (Corey & Corey, 1982).

In working with the elderly it is essential to obtain a complete history and to perform a comprehensive assessment. The history should include information about the client's social history, financial status, emotional well-being, medical condition, and self-care status. In doing the assessment, therapists should look for the client's strengths and remember that the elderly are survivors. When creating treatment plans, therapists should use all possible social networks. Family, social services agencies, senior citizen centers, special senior programs, transportation programs, medical help, public health nurses, and recreation and education programs are just a few possibilities. The therapy environment and materials need to be customized for the elderly. The room should be well-lighted, easily accessible, and in a safe place, and there may be a need for vocal amplification and large print. The pace of the therapy should be slow.

Goals for working with the elderly should be realistic and small. Therapists need to see small changes as important and not expect quick, radical changes. Therapists may have to take an active role and meet survival needs of food and shelter before proceeding to other needs. Therapists' attitudes are also important: the elderly should be viewed as having dignity, intelligence, and something to contribute. They should not be talked to as if they were children or treated oversolicitously.

An important resource for the elderly is the elderly themselves. Peer support and help are valuable assets. They provide help for others and improve the self-esteem of the one who is helping (Lawson & Hughes, 1980). An example of peer help can be seen in group work. Shere (1964) found in a group of people 85 years of age or older who met 47 times that feelings of loneliness and depression lessened, self-respect was regained, old pleasures were revived, social drives were reactivated, intellectual interests were reawakened, and community life was resumed. For the chemically dependent elderly, referral to AA, Narcotics Anonymous, or Al-Anon may provide additional support and networking if there are other elderly at the meetings. The therapist making this kind of referral should investigate the age levels of the groups before referring.

Group therapy for seniors with the goal of making life more meaningful is especially beneficial. The groups need to take a positive approach and have clear goals; task-oriented groups work best. The sessions should go at a slow pace and be supportive. It is not advisable to mix regressed clients with those who are at a high level of functioning. Group themes can include loneliness, social isolation, loss, poverty, feelings of rejection, the struggle to find meaning in life, dependency, feelings of uselessness, hopelessness and despair, fears of death and dying, grief over others' death, sadness over physical and mental deterioration events (Corey & Corey, 1982). Life group members. The elderly are need the same kind of treatment. T be helpful, including groups with special fitness, body awareness, grief work, tation, music and art therapy, commitment and postretirement issues, re people to move from an institutional organic brain syndrome patients, ed poetry, health-related issues, an.

Marriage and family therapy shot the elderly. The elderly may need replaced and increased time with ma on the marriage if old marital problems retirement or when the children h renegotiate old contracts of relating. Family therapy may be very useful that reinforce, hide, or protect sub alcoholism is a multigenerational ill may have similar problems, especi.

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PREVENTION OF SUBSTANCE ABUSE IN THE ELDERLY

Prevention can be seen as keeping them (primary prevention), or keep problems (secondary prevention), worse (tertiary prevention). In pre population, all three strategies app and old age for prevention activ childhood to impact on early one should be directed at the stresses. Early onset alcoholics could be from education campaigns to inter
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t (Corey & Corey, 1982). Life review is healthy and often helpful to
group members. The elderly are a heterogeneous group and do not all
 need the same kind of treatment. There are a variety of groups that may
be helpful, including groups with special emphasis on reminiscence, physical
fitness, body awareness, grief work, occupational therapy, reality orient-
tion, music and art therapy, combined dance and movement, preretire-
ment and postretirement issues, remotivation, preplacement to prepare
people to move from an institution to a community setting, attention to
organic brain syndrome patients, educational seminars, creating and shar-
ing poetry, health-related issues, and family therapy.

Marriage and family therapy should not be overlooked in working with
the elderly. The elderly may need help in negotiating their new status as
retired and increased time with marital partners, which may put a strain
on the marriage if old marital problems were not resolved and surface after
retirement or when the children have left home. Couples may have to
renegotiate old contracts of relating and role behavior. Multigenerational
family therapy may be very useful in making changes in family systems
that reinforce, hide, or protect substance abuse in the elderly. Because
alcoholism is a multigenerational illness, it is likely that others in the family
may have similar problems, especially early onset alcoholics.

Although clinicians are just beginning to learn about the needs, prob-
lems, and life tasks of the elderly, it can be a rewarding experience to work
with this population. Therapists need to look at their own issues with aging
because they too are aging and will someday join an even larger group of
senior citizens. The therapist who learns to help the elderly will undoubt-
edly assure himself or herself of a job for life.

PREVENTION OF SUBSTANCE ABUSE IN
THE ELDERLY

Prevention can be seen as keeping people without problems from getting
them (primary prevention), or keeping high risk people from developing
problems (secondary prevention), or keeping problems from becoming
worse (tertiary prevention). In preventing substance abuse in the elderly
population, all three strategies apply. There is a long time between birth
and old age for prevention activities. Some activities need to occur in
childhood to impact on early onset alcoholics, whereas other activities
should be directed at the stresses of the late onset alcoholic.

Early onset alcoholics could benefit from all of the prevention activities
from education campaigns to intervention with high risk populations. Pre-
vention and treatment programs for children of alcoholics would impact on these early onset alcoholics with a very high rate of familial alcoholism. Better methods of identification of children at high risk, better interventions, and improved treatment programs with higher success rates would reduce the number of elderly who arrive at old age with a long-term substance abuse problem.

Late onset alcoholism appears to be a response to the increased stresses of late life. Prevention activities that reduce these stresses or help the elderly cope with them could reduce the incidences of drug and alcohol use as a coping tool. These prevention activities can be broken down to impact on all three areas of stress: physical, social, and psychological.

Physical stresses will occur as the body wears down with age, but the medical responses to this can be changed to reduce the risk of overmedication, drug interaction, or drug misuse. Physicians must be educated about the special needs and problems of the elderly. They should be aware of the possible misunderstanding, misuse, and self-diagnosing that often occur when they prescribe drugs. Good drug histories can be taken initially and kept current, including questions about alcohol use. Telephone prescribing can be reduced, and physicians can spend more time with the elderly patient explaining the possible problems of non-following directions or the effect of drug interactions. Pharmacists are beginning to check for possible drug interactions by referring to computer records of medications that have been prescribed for each person. Over-the-counter medication companies need to educate the public about the existence of alcohol and other ingredients in their products that can be addicting or cause problems when taken with other medications. This information should be given in a way that the elderly person could hear or see it; writing should be large and prominent.

Social risks can be reduced by increasing the social contact of the elderly person. Volunteer work can replace some of the losses of retirement. Social centers can provide activities that are meaningful and create a place for the elderly to meet others and even begin dating. Social isolation can also include the isolation of being involved only with older people. The elderly need contact with young people and especially children. Day care centers could begin a volunteer program for the elderly to teach skills to the children.

As isolation is reduced, so is psychological risk. Prevention strategies might include increased retirement planning that includes a second career or volunteer work in the first career. The elderly are a wealth of knowledge, and creative programs that put to use the skills learned by the elderly in a lifetime will benefit from this knowledge. Recreation that is designed with the limitations of the elderly in mind can provide a healthy leisure time activity. This can include learning new skills like folk dancing or yoga or finding a way to use an athletic talent people are not skilled at using leisure time to be taught to the elderly before it becomes

Counseling can be a prevention method. Losses are a natural part of the life cycle helped with grief counseling in an individual program. Programs can provide new communicative and establish new patterns for

It is important for the therapist who is in prevention activities or in treatment to respond to most of the treatment approaches if they are given a few special considerate elderly as valuable and able to change.

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ABUSE IN SPECIAL POPULATIONS

Substance Abuse Problems of the Elderly

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be taught to the elderly before it becomes a problem.

Counseling can be a prevention method as well as a treatment approach.
Losses are a natural part of the life cycle, but unresolved grieving can be
helped with grief counseling in an individual or group setting. Marriage
enrichment programs can provide new ways for elderly couples to com-

communicate and establish new patterns for living together.

It is important for the therapist who is working with the elderly either in
prevention activities or in treatment to remember that the elderly
respond to most of the treatment approaches that work with younger people
if they are given a few special considerations and if the therapist views the
elderly as valuable and able to change.

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Alcohol Abuse in the Elderly

CYNTHIA G. OLSEN-NOLL, M.D. and MICHAEL F. BOSWORTH, D.O.
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Alcoholism is often difficult to recognize in the elderly. Information about alcoholic behavior cannot always be accurately extrapolated to older drinkers. Consequences of alcohol abuse and responses to treatment may be quite different in young and elderly alcoholics. Treatment must focus on such day-to-day problems as loneliness, loss of independence and declining health. Gentle persistence is required in guiding the patient to an awareness of the problem.

Physicians are becoming more aware of older drinkers and how alcohol use can affect their health and functioning. Of the estimated 10 million alcoholics in the United States, probably 3 million of them are over age 60.1

"There has been an increase in mortality from alcohol abuse in the elderly, and many alcohol-related deaths are not reported. This is due, in part, to a failure to recognize how alcohol contributes to deteriorating health in older patients."2

Classification of Elderly Alcoholics

Investigators of geriatric alcoholism have divided patients into three major groups: survivors, intermittent drinkers and reactors. Each group has specific characteristics and responses to treatment.

In the survivor group, which comprises two-thirds of older alcoholics, problem drinkers have an early onset of alcohol abuse. While most alcoholics are expected to die at an earlier age, survivors have "beaten the odds." Most of these older drinkers have numerous medical problems, including cirrhosis, organic brain syndrome, psychiatric problems and other disorders.

Little has been written about intermittent drinkers. People in this presumably sizable group are usually occasional binge drinkers, but they may become frequent alcohol abusers as a result of the stress associated with aging in our society.

"Reactors are individuals who start drinking late in life. In these patients, alcoholism is secondary to the stress of aging and is harder to diagnose. Because of the late onset of their drinking, reactors show fewer physical consequences and fewer lifestyle disruptions than other alcoholics. It is estimated that up to one-third of elderly problem drinkers fall into this category. In this group, women outnumber men."3

The male-to-female ratio among elderly problem drinkers in general is approximately 5:1.4 Women are more likely than men to start drinking heavily later in life and single women are more likely than married women to have an alcohol problem. Subgroups of the elderly at risk for alcohol abuse appear to be widowed single individuals, those with criminal records, blue-collar workers and those living in disadvantaged areas.

Glynn and co-workers5 showed that drinking patterns are stable over time. Male drinking behavior is defined early in youth, and there is little change in behav...
Alcohol Abuse in the Elderly

ior after age 30. However, not all young alcoholics continue drinking in later life. Regardless of the age at which drinking begins, evidence suggests that an alcohol abuse "career" may run a regular course that results in spontaneous recovery after 20 to 25 years. Some investigators have even suggested that early-onset alcoholism is a self-limited disease and that this type of drinking "burns out" with advancing age. Similar findings have been reported in opiate addicts, but more research is needed in this area.

Characteristics of Elderly Alcoholics

Criteria normally used to define alcoholism may not pertain to the elderly. For example, the lifestyle disruptions that result from heavy alcohol use are often absent in the elderly. The elderly are less likely to have serious problems with the police and the legal system. Although behavioral problems have been reported in the elderly, they do not necessarily indicate deep-seated psychopathology. Compared with younger alcoholics, elderly drinkers have fewer signs and symptoms of alcoholism and less frequent physical sequelae. Older alcoholics are also less likely to attempt suicide. Alcoholics over 60 are more likely to be white than black, and are more likely to be divorced or separated and living alone.

Information about alcoholic behavior cannot always be accurately extrapolated to older drinkers. For example, the elderly problem drinker is more likely than the younger drinker to offer information to the physician about alcohol abuse and is more likely to seek and stay with treatment. An early, stable life adjustment is more frequently reported in these older drinkers.

Overall, areas of alcohol-related pathology are more limited in this group.

Problems associated with alcohol abuse in the elderly may be primarily social rather than medical. Although the elderly may have chronic medical problems, it has been shown that there is rarely a need for alcohol detoxification or withdrawal in these patients. Consequently, elderly alcoholics may be easier to treat, may not require traditional methods of alcohol rehabilitation and may be amenable to simple socialization techniques to help combat the causes of their alcohol abuse.

These differences between elderly and younger alcoholics may be due to the large proportion of elderly drinkers who have started abusing alcohol later in life.

Physiologic Consequences

The elderly respond differently to alcohol use than younger individuals. Unlike the euphoric response to alcohol that is common among young drinkers, a dysphoric reaction often occurs in elderly people. Other uncomfortable effects include headaches, reduced cognition and memory deficits.

Overall, the response to alcohol tends to be much stronger in the elderly than in younger people. Reasons for the increased sensitivity to the effects of alcohol include the age-related decrease in lean body mass as opposed to total volume of fat. The resultant decrease in total body volume increases the total distribution of alcohol in the body. The efficiency of liver enzymes that metabolize alcohol also decreases with age. Conversely, central nervous system sensitivity to alcohol increases.

In evaluating the physiologic consequences of drug and alcohol use in the elderly, whether alone or in combination, investigators have found that the adverse health effects are not limited to those patients who are considered to have a drink-
ing problem. Some elderly patients with serious illnesses can have adverse consequences from even moderate consumption of alcohol or drugs.

One of the most important physiologic consequences of alcohol use in the elderly is the effect on the cardiovascular system. Because older people have more cardiovascular disease in general, they are at higher risk for serious complications. In elderly drinkers, anginal pain may be deadened and possibly ignored, leading to myocardial infarction. Studies have shown that patients under the influence of alcohol can work harder than others before anginal pain develops, even when there are electrocardiographic findings of ischemia. Cardiac function is impaired by alcohol, resulting in decreased cardiac output and efficiency. This can occur with as little as one drink. Worsening of hypertension can be correlated with consumption of approximately three drinks a day. Finally, alcohol use is associated with an increase in free fatty acids and can exacerbate hyperlipidemia.

Changes in pulmonary status have also been noted. For example, alcohol abuse can cause a decrease in respiratory drive, resulting in increased mental confusion in patients with chronic obstructive pulmonary disease. Alcohol abuse also has adverse nutritional effects in elderly patients, including deficiency of thiamine and other nutrients.

Gastritis, peptic ulcer disease and diarrhea are common among elderly drinkers. Alcohol-related disorders of the neuromuscular system include myopathy, neuropathy and cerebrovascular disease. Alcohol not only decreases coordination but also lowers the seizure threshold.

Obtaining a detailed medication history is imperative in elderly patients. A 1979 study revealed that the average older patient takes four over-the-counter drugs a day. The patient with chronic disease may take as many as five to 16 different drugs. Because of the number of medications they use, elderly alcoholics may have problems with drug interactions. Of the 100 most frequently prescribed drugs, 50 interact with alcohol, and of the 10 most prescribed drugs, all do.

Psychosocial Factors

Many social transitions are made as individuals enter the latter part of their lives and these changes may contribute to increased alcohol consumption. Retirement is one of these transitions. A hard-working productive person who has never had time for hobbies may find retirement difficult. It has been suggested that alcohol is sometimes used to relieve boredom and the retired persons may frequent bars or clubs for social contact. Those who have unrealistic expectations of retirement may drink because they are depressed and these expectations are not fulfilled. A decline in economic status may also contribute. Other stressors in old age include the loss of one's friends, or spouse, loneliness and physical discomfort from ailments such as arthritis and osteoporosis.

The theory of "learned helplessness" may help explain why depressed elderly people may abuse alcohol. According to this theory, a cognitive defect may lead a person to believe that circumstances contributing to his or her depressed condition cannot be changed. The result is a tendency to stop trying to change the unfavorable conditions.

Why Elderly Alcoholics Go Undiagnosed

Diagnosing alcoholism in the elderly can be difficult. In a 1981 study involv
188 female nursing home patients, 17 percent of these patients were found on close examination to be alcoholics, whereas only 1.5 percent had been previously recognized as having a drinking problem.

There are many rationalizations for not confronting elderly problem drinkers.11 Family members and physicians may accept an ongoing drinking problem as a justifiable response to the recognized stress of aging in our society. Another obstacle to recognizing the elderly alcoholic is the stereotype of the "skid row bum." Because the elderly alcoholic may not fit this stereotype, alcohol abuse may not be suspected.

For various reasons, elderly alcoholics may not come to the attention of those who might suspect their drinking problem. As mentioned earlier, they are less likely than younger alcoholics to have police records or to have trouble with the law. The perception that older alcoholics are seldom a public nuisance, however, has proved to be in error. A 1970 study done in San Francisco7 revealed that of 722 individuals over 60 who were arrested, 82 percent were charged with public drunkenness.

Because retired individuals no longer have job responsibilities, they do not have work-related problems resulting from their alcoholism. Elderly alcoholics who are still working but are functioning minimally may be carried along by their employers as a reward for many years of service or in anticipation of upcoming retirement.9 Many elderly people receive health care from a number of providers, and information that would raise the suspicion of alcoholism is never pulled together. In addition, more than 1 million men and 5 million women live alone or with nonrelatives.3 Those elderly persons who live alone are less likely to be brought in for detection and treatment of alcoholism.

When behavioral problems develop in the elderly, other causes are often considered first. Many transient psychiatric syndromes associated with alcoholism are indistinguishable from senile dementia.8 Frequently, alcoholic behavior is thought to be caused by a serious depression, acute psychosis or abrupt-onset organic brain syndrome.18 The chronic use of alcohol may produce symptoms that simulate those associated with Alzheimer’s disease or multiple infarct disease.

Because of the difficulty in diagnosing alcoholism in the elderly, a high index of suspicion is needed and indications of alcohol abuse must be investigated. Medical ward patients should be screened thoroughly for evidence of alcohol abuse.

Diagnosis

Many psychologic screening tests are designed for use in identifying the problem drinker.16,23 When these tests are not available, however, the physician must rely on the history and physical examination.
Clues in the history that may indicate a drinking problem include insomnia, increased frequency of dreaming or changes in the sleep pattern. A history of abrupt confusion, frequent falls, burns, bruises or sprains may also suggest a drinking problem.

Inability to function may also be a sign of alcoholism in the older patient. Evidence of self-neglect, poor grooming or malnutrition may indicate a drinking problem. (Paradoxically, meticulous grooming in the presence of an untidy household may suggest that the patient is trying to hide an alcohol problem.)

When a patient has increased problems with control of gout, diabetes mellitus, hypertension or angina, or develops incontinence, the physician should consider the possibility of alcohol abuse. Cold injury, accidental hypothermia and unexplained hyperuricemia should be investigated. Also, unexpected responses to prescription drugs may alert the physician to the diagnosis of alcohol abuse.

Noticeable behavior changes, such as social isolation, paranoid behavior, increased family quarrels or estrangements from family and friends, should be investigated. Frequent emergency room visits have been reported in alcoholics.

Treatment

Unfortunately, only 15 percent of elderly alcoholics receive adequate treatment for their disease. Often the older alcoholic will not seek treatment until medical problems arise. Overall, elderly problem drinkers are more likely than younger drinkers to enter and stay in treatment.

Late-onset drinkers, the reactor group, generally respond best to treatment.

Treatment should focus on day-to-day problems, such as adjustment to relocation and other transitions. It has been suggested that the goal for the problem drinker is not sobriety but rather lifestyle changes that will offset alcohol abuse. Better community and family education is needed so that elderly alcoholism is not ignored.

Greater coordination of physicians, social agencies, geriatric mental health agencies and persons knowledgeable about the financial and transportation needs of the geriatric population would improve the quality of life for the elderly.

The absence of physical distress associated with alcohol abuse may make the elderly alcoholic reluctant to seek a specialized alcoholism treatment program. Treatment intervention can be effective when delivered through facilities that specifically serve the aged. These may include senior citizen programs, outpatient psychiatric medical or psychiatric programs, nursing homes or home-care programs. Some investigators even suggest that older problem drinkers can benefit from entering a nursing home to improve sociability and maintain sociality for several months before return to the community.

Droller showed that elderly alcoholics can be treated in their homes when medical and social therapy are provided. Rosin and Glatt reported successful treatment of 103 elderly alcoholics using environmental manipulation and services along with day hospital care, home visits by staff and neighbors. However, some elderly alcoholics may need to be hospitalized initially.

Elderly patients are often unwilling to enter a hospital for treatment, because they are concerned about leaving their home unprotected or about making arrangements for their hospital stay. Inpatient treatment, however, is often needed.
dress such issues as poor nutrition, weight loss, polypharmacy, and frequent falls. During hospitalization, problems that have led the patient to alcohol abuse may become evident. Individual counseling and support are crucial in alleviating the patient’s frustration and depression.

When treatment for alcoholism is begun, the patient should be informed that a normal sleep pattern will return in two to three weeks, but that symptoms of irritability and anxiety may continue longer. (It is important to avoid the use of benzodiazepines to improve sleep during this period of sobriety.)

The use of disulfiram (Antabuse) has not proved useful as an adjunct to alcohol rehabilitation in the elderly. It may lead to serious alcohol-disulfiram reactions, and its use should be avoided.

With the elderly, strong confrontation may be less effective than gentle persistence in guiding a patient to an awareness of the consequences of alcohol use. A goal for the physician should be to help the patient break through “learned helplessness.” Time and a supportive attitude will eventually result in trust and communication, the first steps toward helping the problem drinker.

The patient should continue to have adequate social and psychological evaluation and follow-up. Determining the state of the patient’s environment may be very useful in the initial phases of rehabilitation and will help the patient once he or she reenters the community as a sober person. Helping the patient identify and focus on strengths and interests may aid in recovery.

Counselors should concentrate on relevant issues such as retirement, free time and volunteer work. Other issues include interactions with grown children and autonomy. Many elderly persons may be dealing with sexual frustration and inadequacy, chronic illness and pain, poor nutrition or financial problems. Alcoholics Anonymous (AA) can guide the elderly alcoholic to appropriate retirement societies and peer groups.

The elderly are more faithful than younger patients in attending meetings of support groups, but they prefer and receive greater benefit from smaller groups. Older patients complain about the high noise level, the rough language and the cigarette smoke that are often associated with large group meetings.

After discharge from a treatment facility, the elderly patient may need transportation, especially at night. In order to attend follow-up meetings, the family physician should make sure the patient is able to come to the office for follow-up visits. Follow-up phone calls and peer counseling have proved successful. Visiting nurses should be employed to assist homebound patients. Often the elderly are concerned about the financial aspects of rehabilitation. They need to know that treatment for alcoholism is reimbursable under Medicare and Medicaid.

Final Comment

Older problem drinkers are not a homogeneous group; they have individual needs and concerns. Some may resist help and deny treatment because of moral attitudes toward alcoholism. Most elderly drinkers need to improve their self-image and be assured that they are not useless members of society. Reminding these patients of their years of productivity can aid in their recovery. Ignorance, fear and prejudice about aging create barriers to adequate help and support. Physicians need to emphasize to these patients that they must adjust to the changes that occur in life rather than to old age itself.
EDITOR'S NOTE: We've held back Robert Moore's regular monthly column, "Feedback," in order to share an important "feedback" resulting from his column, "Alcohol and the Elderly" which appeared in the April, 1993 issue of The National Journal of Health and Recovery. Moore, CAC, NCACII, is president of the New York Federation of Alcoholism Counselors. The popular Moore also hosts Recovery Radio, a community response program sponsored by The Seafield Center, Westhampton Beach, NY, on WGBB Radio Wednesday mornings from 10 am to 11 am (1240 AM). You can reach Moore by writing him c/o The National Journal of Health and Recovery, PO Box 645, Sag Harbor, NY 11963.

Dear Mr. Moore,

I am writing in response to your article, "Alcohol and the Elderly" (Journal of Health and Recovery, April 1993). Please find enclosed an Executive Summary of a 20 page report entitled "The Community's Invisible Drug Problem: Substance Abuse and the Elderly". The report represents the work of over 15 Monroe County agencies concerned by the issue of elderly substance abuse. The Consortium on Elderly Substance Abuse was formed to heighten public awareness regarding the issue, educate care givers in the signs and symptoms of substance abuse in the elderly, increase accessibility to treatment and the removal of barriers (personal, governmental and financial) that impede this population's entry into care. The City of Rochester and Monroe County have addressed this issue as a community problem. Thus, engaging the various community entities (media, government, providers, etc.) in its resolution. It is only with such a systematic approach will the elderly substance abuser be identified and provided with the care they need.

Sincerely, Michael Campo, CAC, NCACII, Rochester, New York

Rochester Fights Back! From the original ED.

A Community's Invisible Drug Problem: Substance Abuse and the Elderly

Executive Summary of a 20 page report from Consortium on Elderly Substance Abuse (CESA), Regional Council on Aging, Rochester, N.Y.

Independent studies estimate that at least 10% of the population age 60 and older has a problem with chemical dependency. Applying these national data to Monroe County we estimate that 12,000 seniors are abusing alcohol or drugs. In 1992 the House Select Committee on Aging released a report which indicates that "alcohol problems may be the fastest-growing and most severe health threat to senior citizens". Among the findings of the report are:

* the rising trend in late life drinking coincides with trends in earlier retirement, leading some experts to believe that unexpected pressure stemming from this change may trigger a drinking habit.

* widowers have the highest rate of alcoholism among any age group.

The Mayo Clinic estimates only 15% of older adult alcoholics are receiving appropriate treatment. Yet the Congressional study found that seniors have the highest rate of cure among those treated for drinking problems, but they are the least likely to seek help. Seniors also suffer from abuse and misuse of medications. A 1991 report from the NYS Assembly reports that in 1985:

* 39% of hospitalizations and 51% of deaths due to drug reactions occur among the elderly. * 32,000 elderly incur hip fractures each year due to drug induced falls.

Continued next page
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Continued from previous page

* In 1983 drug related hospitalizations, as well as post hospital treatment for the elderly cost $4.5 billion. The most widespread problem is the mixture of alcohol and medications. Alcohol causes a reaction when mixed with the most commonly prescribed medications, sometimes reducing the effectiveness of the med's, sometimes increasing the effect of the alcohol and also causing dizziness or internal bleeding. A corollary to the problem of elderly substance abuse is the inability of many physicians to appropriately medicate seniors and adequately assess drugs or drug/alcohol interactions in the population.

* fewer than 2% of American medical students enrolled in 1988 were required to take courses in geriatrics or geriatric pharmacology.

* a 1985 questionnaire of doctors treating Medicare patients found that over 70% failed a test in prescribing drugs for this group.

II. Local Activity on this Issue

Impetus for activity on this issue in Monroe County has come, to date, from a Steering Committee (CESA - Consortium on Elderly Substance Abuse) which grew out of conference on Substance Abuse and the Elderly held in October, 1991. An informative brochure is available and a speakers' bureau is active throughout the community. CESA, with the assistance of a group of Brockport senior nursing students, put together an ideal comprehensive system on the subject of elderly substance abuse.

III. Services Available

Park Ridge Chemical Dependency provides the most comprehensive array of services for seniors in this area. The full CESA Report includes three charts which identify all agencies in Monroe County which provide substance abuse services for seniors, the extent to which human service agencies identify seniors with substance abuse issue and the extent to which providers address their needs.

Only 400 elderly persons were identified as needing services, compared with over 12,000 estimated by applying national information to Monroe County demographics.

IV. Barriers to Care

There are many reasons why substance abuse among seniors goes unrecognized and untreated. These are:

1. Attitudinal barriers, such as mindsets which inhibit obtaining adequate information to take drugs properly, the recognition of substance abuse in seniors, the recognition of the need to treat these problems in seniors

2. Isolation factors, The typical signs that frequently identify younger substance abusers -- not seen in a retired person -- are poor work performance, driving "under the influence", becoming drunk in public or abusing a spouse.

(3) Service system inadequacies, which include:

* shortage of treatment programs specifically for senior
* lack of community-wide screening & assessment tool
* lack of education among health care providers.
* lack of senior-friendly entries to care.
* lack of in-home assessment capabilities.
* insufficient programs dealing with grief and loss.

(4) Reimbursement constraints include inadequate reimbursement by principal payors, lack of public and professional awareness of which services are reimbursable and the relationship between services needed and services which are reimbursable.

V. RECOMMENDATIONS FOR ACTION

The goal is to have a comprehensive system of substance abuse services tailored to the needs of seniors. To reach this goal 15 short term objectives have been established, a few of which are listed here:

1. A series of education initiatives should be undertaken to raise the consciousness of the general public and health care providers.

2. Screening and assessment tools adapted for senior substance abusers should be developed and adopted for community-wide use.

3. Hospitals which serve large number of seniors provide an array of acute, long term care and substance abuse services, should be encouraged to develop a holistic model of substance abuse services for seniors.

4. Family Service of Rochester, in conjunction with Rochester Housing Authority, should be encouraged to develop senior sober housing programs.

5. Hospitals and nursing homes should be encouraged to use clinical pharmacologists trained in geriatrics to assist them with medical care evaluation studies focused on practices in prescribing and managing medication for the aged.

6. The HSA should conduct a study to determine how many senior hospital days are related to substance abuse.

This is an executive summary of a 20 page report which offers more details and the sources of the various studies quoted. We encourage you to refer to that report for more information. To obtain copies of the Executive Summary, the full report or the informative brochure or to arrange a speaker contact CESA (Consortium on Elderly Substance Abuse) c/o Regional Council on Aging 79 N. Clinton A Rochester, N.Y. 14604 (716) 457-3224. Ask for Michelle Campo, Public Relations Coordinator. E.D.
LIGHT
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Drinking Problems May Emerge in Older Adults

One of the ironies of modern life is that the "golden years" are not always golden. Illness, neglect, poverty, and loneliness can be the bane of aging men and women, and for some, these years bring personal problems with alcohol.

Heavy drinking is less visible in the older population, but it is a source of real health and safety concerns for many and a serious concern to their families. And with the graying of America, the issue is sure to boom larger on the societal scene.

Data suggest that untreated alcohol abuse among older persons is a more serious problem than has been previously recognized and it is likely to become an even greater problem as the "baby boom" portion of the population ages," says Enoch Gordis, MD, director of the National Institute on Alcohol Abuse and Alcoholism.

The number of older adults in the United States is expected to rise from 36 million in 1980 to 49 million by the year 2030, one out of every four Americans will be 60 or over.

This demographic trend has made it imperative to know more about the health problems of older Americans, a consideration that led to the convening of the Surgeon General's Workshop on Health Problems of Older Americans.
The Workshop's Alcohol Working Group made recommendations in the area of education and training, delivery of services, and research. These were the highlights:

- **Social service providers**, home aides, and others working with older adults should be informed about the potential for alcohol abuse among their clients. They need to know how to identify alcohol problems, where to refer clients to find help, and how to advise family members about their role in dealing with the problems.

- Physicians and other health professionals should be trained to understand patterns of alcohol use or abuse among older persons. They should know techniques of intervention, and how to communicate with patients about alcohol use.

- Treatment and recovery programs for older persons with alcohol problems should be community-based rather than hospital-based. There should be networking among state and local service agencies to improve identification, referral, and treatment of older alcoholics.

- Research is needed in a number of areas involving older drinkers, especially the interplay between alcohol use and the aging process and the association between alcohol and cardiovascular disease.

The Surgeon General's Workshop took special note of the confusion over the latter issue — whether small or moderate amounts of alcohol in an older person's diet may actually reduce the risk of heart disease and stroke. Some studies have concluded that moderate drinking (no more than two drinks a day) can have a beneficial effect, but others have contradicted it. The Workshop concluded that more information is needed before a comprehensive public health policy can be established on the subject.

As matters stand, older Americans may be confused over whether daily drinking is good for them — or an invitation to dependence on alcohol or a potentially dangerous mixture of alcohol with prescription drugs.

The Workshop's final report called for improved and expanded epidemiological studies of alcohol consumption patterns and health outcomes in the aging population and for specific investigations of the relationship between alcohol and cardiovascular disease.

Research into drinking by older adults is already on the upswing. In 1988, the National Institute on Alcoholism and Alcohol Abuse announced a five-year grant to the University of Michigan Medical Center to explore the effect of alcohol on the aging process. In 1990, NIAAA announced a new program of research grants to study prevention techniques especially aimed at older adults.

Interestingly, studies of alcohol consumption based on self-reporting usually show that older adults drink less than those in younger age groups. Researchers suggest several explanations among them the simple fact that retirees and other older people usually have less money to spend on alcohol than younger people. The changing metabolism that goes with aging can make older people more susceptible to the effects of alcohol. Those who consider themselves moderate drinkers in earlier years may find that consuming the same amount of alcohol leads to trouble as they grow older.

Falls are a common consequence of drinking by older persons. A study reported in 1990 at a Detroit conference on aging found that 60 percent of older people who suffered spinal cord injuries in falls had been drinking within a few hours of falling. Most of the falls would be classed as minor accidents, like falling down a step or two.

"These falls wouldn't even necessitate a trip to the emergency room if the people were younger," said researcher Phyllis Graham of the Southeastern Michigan Spinal Cord Injury Rehabilitation Institute. "But in the older, alcohol and aging combine to turn small falls into catastrophes."

A study published in 1985 estimated that annual
People are not as useful where older people are concerned. Absenteeism and problems at work which often reveal problem drinking in younger men and women do not occur in those who are retired or do not have job responsibilities. And even when older alcoholics are still working, their colleagues or employers may wink at the evidence of their drinking problem. “After all, old Joe will be retiring soon...”

Older adults also are less likely to have run-ins with the police or otherwise get into trouble with the law even which can call attention to an alcohol problem. Many elderly people receive health care from a number of different providers, so information that might point to an alcohol problem is never viewed comprehensively by a single practitioner. Often, behavior resulting from heavy drinking is attributed to depression or some other mental illness.

There is a bright spot in this picture. Treatment providers report that older adults, when confronted with the reality of their alcohol problem, are more willing than younger persons to enter a recovery program and stick with it.

The Family Physician article calls for better community and family education about alcohol and the elderly. It urges greater coordination among physicians, social agencies, geriatric mental health agencies, and persons knowledgeable about the financial and transportation needs of the geriatric population.

Helping older adults deal with alcohol problems may mean getting them interested in volunteer work or otherwise changing a solitary lifestyle. They often need transportation to broaden their social life or to attend meetings of support groups such as Alcoholics Anonymous.

The National Council on Alcoholism and Drug Dependency, in a pamphlet on older people and alcoholism, makes the point that mature citizens awakened to the role of alcohol in their lives and the lives of others like them can become useful advocates for senior causes.

“Older people need...and deserve the opportunity to live their lives productively and with dignity. Alcohol problems often begin for older people when they do not have this opportunity. Raising consciousness about the needs and requirements of living meaningfully in the senior years is one way for older people to make an impact on their own circumstances...”

“The experience and knowledge which older people have gained make them persuasive activists for their own cause in citizens’ and political groups.”

...
TESTIMONY

by

MICHAEL S. RABIN
DEPUTY COMMISSIONER
NEW YORK CITY DEPARTMENT FOR THE AGING

on

DRUG AND ALCOHOL ABUSE AMONG THE ELDERLY IN NEW YORK CITY

at a
HEARING
before the

Committee on Aging
Jointly with the
Subcommittee on Mental Health, Mental Retardation, Alcoholism and Drug Abuse

250 Broadway--23rd Floor

January 24, 1995
10:00AM
Good morning, I am Michael Rabin, Deputy Commissioner and General Counsel of the New York City Department for the Aging. On behalf of Commissioner Herbert Stupp, I am pleased to have this opportunity to comment on the issue of drug and alcohol abuse among the elderly in New York City.

As you know, the Department is both an agency of City government, and the largest Area Agency on Aging in the Nation, representing 1.3 million elderly. A primary objective of our Department is to support the independence, dignity and physical and mental well-being of all older New Yorkers. For example, through our Health Promotion Services Unit, we offer health education activities in many of our senior centers. Our program trains volunteers to lead health forums, exercise classes, stress management and discussion groups that help seniors take charge of their own well being. Through our Information and Referral Unit, we are also able to refer persons with substance abuse issues to appropriate treatment programs, including those administered under the Department of Mental Health, Mental Retardation, and Alcoholism Services. Our two agencies have collaborated over the past six years, through the New York City Interagency Council on Older Persons, Alcohol and Other Substances, to improve services for older New Yorkers struggling with alcohol and other substance abuse problems. As previously mentioned by the Department of Mental Health, Mayor Giuliani is committed to addressing this problem through our interagency cooperation.
Substance abuse by the elderly represents a breakdown in an individual's well being, and is a health problem that is of great concern to us. We are pleased that the City Council Committee on the Aging and Sub-committee on Mental Health, Mental Retardation, Alcoholism and Drug Abuse have provided this forum to address this important issue.

Substance abuse by the elderly is a problem which, if undetected and untreated, can lead to serious illness and early death. A 1992 Report by the Subcommittee on Health and Long-Term Care of the U.S. House of Representatives Select Committee on Aging revealed that alcoholism is the third most common disease in the United States, and the ninth leading cause of death. According to this report, alcohol abuse among the elderly results in "depression, malnutrition, insomnia, cognitive problems and loss of interest in life." Alcohol abuse among the elderly also leads to high rates of hospitalization. Estimates of institutionalized elderly with alcohol-related health problems range from 15% to 44%.

Estimated rates of alcohol abuse by the elderly range from 2% to 15% of the elderly population. In New York City, the 1990 U.S. Census found that there were 143,939 persons aged 60 and over in need of alcoholism treatment, which is more than 10% of the City's total senior population.

These rates may not even reflect the full magnitude of the problem. The greater social isolation of seniors and an increased likelihood that they will withhold information about
their actual levels of consumption may mean that the problem is not always identified or reported. A lower rate of self-reporting by the elderly may be due to a stronger association of alcohol consumption with social stigma, or the application of measurements for determining problem drinking according to rates of consumption that are more applicable to a younger population with different metabolism rates. The estimated rates of alcohol abuse among the elderly must also be seen to reflect the fact that prolonged, heavy drinking prevents a portion of the younger population from ever reaching advanced age.

Although alcoholism among the elderly is more likely to be hidden from family and physician because of the greater isolation of the elderly and a lower likelihood of self-reporting, older adult alcoholics have been found to be more responsive to treatment, and have a higher one-year sobriety rate, than younger age groups. Alcoholism among the elderly can, in about 33% of all cases, be linked to stresses and life events that are part of the aging process, including bereavement, retirement, and loneliness. In these cases, it has been found to be more easily treatable.

An effective model for combatting alcohol abuse among the elderly must encompass preventative measures through public education; outreach to identify the alcoholic in need of help; and participation in intensive treatment through detoxification centers, hospital or outpatient treatment or group therapy. Treatment programs must also be sensitive to the special service
needs of older individuals.

A second, more prevalent, form of substance abuse among the elderly is prescription drug misuse. Senior citizens are at increased risk of medication misuse because of their higher overall use of prescription drugs. A 1991 New York State Assembly Summary Report on the misuse of prescription drugs by the elderly revealed that an estimated 50% of all prescribed medication is used incorrectly, either through undermedication, overmedication, or use of medication for other than its intended purpose. The report stated that, according to the Food and Drug Administration, an estimated 80% of adults over age 65 have at least one chronic condition that requires long term prescription medication, and often involves combining several different drugs. Twenty five percent of elderly living in the community use three or more different drugs every day.

Prescription drug misuse can result from adverse interactions of multiple prescriptions, inability to understand instructions, or failure to take the prescribed medication. The consequences of drug misuse include adverse drug reactions ranging from nausea and fever to life-threatening complications such as hemorrhage or renal failure. Drug misuse can also lead to changes in perceptual and cognitive capabilities and depression. According to a 1985 study by the Department of Health and Human Services, an estimated 243,000 older adults were hospitalized because of adverse drug reactions. The study found that older Americans account for 39% of all hospitalizations, and
51% of deaths, as a result of adverse drug reactions. Each year, 32,000 elderly suffer hip fractures as a result of drug-induced falls, and 163,000 elderly experience severe mental impairment that is either caused or exacerbated by drugs.

Prescription drug misuse can be even more problematic if an older individual is also abusing alcohol. If unrecognized by a physician, it can lead to unintended dangerous, even fatal, interactions with prescription medications. Because the elderly are more likely to be physically weaker than younger persons, or to be taking prescription or over-the-counter drugs on a regular basis, the risk of adverse reactions or harmful effects of alcohol consumption are particularly high.

The Department for the Aging has long advocated for legislative and programmatic initiatives to address the problem of substance abuse among the elderly. On the Federal level, we have advocated for legislation that would authorize the Food and Drug Administration (FDA) to require that pharmaceutical companies include a proper proportion of the elderly in clinical trials of drugs to be used by the elderly. Prescription drugs can affect the elderly in different ways than younger people because of their greater chronic health problems requiring multiple medications as well as changes in dosage requirements due to age-related biological changes. Older Americans use up to 33% of all prescription drugs, yet tests of a drug’s safety and efficacy are primarily conducted with subjects between the ages of 20 and 60.
On the State level, we applaud recent improvements in the Elderly Pharmaceutical Insurance Program (EPIC) that automatically alert pharmacists, through a computer data base, when patients are being prescribed medication that would be incompatible with other medications they may already be taking. We encourage the development of a more uniform system, similar to one recently proposed in the Medicaid Task Force Report to Governor Pataki, that would require pharmacies to screen for prescriptions for incompatible medications in order to reduce the risk of adverse reactions.

We believe that geriatric pharmacology must be given greater emphasis in medical and pharmacy schools so that doctors and pharmacists have a better understanding of the very different impact that drugs can have on the elderly.

Locally, we will continue to work with the Department of Mental Health, Mental Retardation and Alcoholism Services to promote awareness, outreach, treatment and prevention for the elderly substance abuser. Together, through the Interagency Council on Older Persons, Alcohol and Other Substances we look forward to planning the fifth conference on substance abuse among the elderly, and to move forward with the development of resource materials on this important issue.

Thank you again for providing this forum to explore issues and solutions to the problems of drug and alcohol abuse among the elderly in New York City.
TESTIMONY

provided to

City Of New York Council
Committee on Aging and the
Subcommittee on Mental Health, Mental Retardation, Alcoholism and Drug Abuse Services

at a hearing on
Drug and Alcohol Abuse Among Elderly in NYC

January 24, 1995
Drug and Alcohol Abuse Among the Elderly of NYC

Good Morning. My name is Joanna Mellor and I thank you for the opportunity to speak at this City Council hearing on Drug and Alcohol Abuse Among the Elderly in NYC. I am the Executive Director of the Hunter/Mount Sinai Geriatric Education Center, a federally funded consortium between the Department of Geriatrics, Mount Sinai Medical Center, and the Brookdale Center on Aging of Hunter College. Our mandate is to provide geriatric education to health care professionals. I am also a member of the NYC Interagency Council on Older Persons, Alcohol and Other Substances. The Interagency Council is a group of concerned persons representing the aging and substance abuse service systems, who meet to exchange information, develop service linkages, and provide educational leadership to service providers on this topic.

Introduction

Estimates of the extent of substance abuse among older persons vary because there is little consensus on defining the population. In general, however, old age for the substance abuser is considered to begin at 55 years of age and a person is identified as having problems with alcohol or other substances if the amount consumed creates problems in the life of the individual. Using these definitions, it is estimated that between 10 to 15% of older persons have problems with alcohol and/or other substances, (i.e. 2.5 to 3.75 million persons nationwide). Among older persons in the health care system, the percentages
are even higher. Studies indicate that seventy percent of elderly hospitalizations in 1991 were for alcohol related problems and more than 20% of hospitalized older persons have a diagnosis of alcoholism. The cost of alcohol related hospital care for the elderly has been calculated as high as 60 billion. (Select Committee on Aging, 1992.) Within nursing homes, an estimated 50% of residents have alcohol related problems. In NYC with 1.28 million persons over the age of 60, it can be estimated that 128,000 to 192,000 older persons have problems with alcohol and/or other substances.

Many of the studies and estimates focus on older persons with alcohol related problems as, until recently, little thought was given to older persons with other substance abuse problems. Service providers are now seeing dual addicted older persons and the incidence of heroin, cocaine, and crack abuse is not uncommon. Most of the literature and known information refers to the older person with alcohol problems and my statements refer to this population, although we cannot ignore the abuse of other substances among older persons. More research is needed to provide the hard data for the reality being seen by health and social service providers.

Special Characteristics of this Population

Altered Tolerance for Alcohol. With increasing age, the body's ability to absorb and dispose of alcohol changes and tolerance for the substance diminishes. Thus only one or two drinks in an older person may equal in effect a much larger
consumption of alcohol by a younger person. Persons who have never formerly experienced difficulties with alcohol may find, as the body changes, that they begin to exhibit signs of alcohol abuse even though the alcohol intake remains constant.

**Alcohol and Medications.** Use of alcohol is aggravated by use of prescription and over-the-counter drugs. The older population is a disproportionately large consumer of medications, consuming 31% of all prescription drugs in this country in addition to a wide variety of non-prescription medications. It is conservatively estimated that 40% of older persons are using over-the-counter drugs on a daily basis and 80% of these also use alcohol, prescription drugs or both. Older persons are also more likely than younger persons to be taking multiple medications and already in danger of adverse drug reactions. Adding alcohol, even in relatively small quantities, can cause serious problems.

**Lack of Detection or Misdiagnosis.** Abuse of alcohol and other substances is frequently undetected in the older population. Firstly, abuse of alcohol may be hidden as older persons may be living alone and less visible to the community at large. The commonly used indicators of job performance and driving ability may be inapplicable. Secondly, the symptoms of alcohol abuse may mimic symptoms of age-related problems (loss of appetite, sleep disturbances, falls, malnutrition, polypharmacy) and can be misinterpreted as such or overlooked entirely.

**Cultural and cohort beliefs.** As with younger age groups, different cultures, ethnic groups and cohorts of the population hold different views and attitudes towards the consumption of
alcohol. The current cohort of older persons holds its own views concerning the place of alcohol consumption in daily living. Interpretation of what constitutes a problem with substance abuse varies.

Stereotyping and Ageist Attitudes. Family, friends and caregivers tend to overlook signs of substance abuse rather than identify a problem which carries with it the stigma of disease. Even if symptoms are recognized as abuse of alcohol, there is a persistent belief among families and professional workers that older persons have little left to live for and should not be deprived of the pleasures of alcohol. Closely connected to this is the stereotypical view that older persons cannot change their behavior and treatment is worthless.

Categories of Older Persons with Problems with Alcohol

Studies of alcoholism and older persons identify three distinct categories of older persons who experience problems with alcohol. These are:

1. the early-onset drinker. These are persons who have abused alcohol throughout life and are now chronologically aged. This group is likely to have life threatening medical conditions - cirrhosis of the liver, brain damage, cardiac problems, depression, anxiety and alcoholic hallucinosis. (Approximately one third of older persons with problems with alcohol fall into this category.)

2. the late-onset drinker. These persons manifest a problem with alcohol only in old age. The late-onset drinker is less likely to
have a history of psychological problems and the drinking may be a response to the stresses of aging - depleted finances, medical problems, isolation, retirement stresses, widowhood or loss of independence. (Almost two thirds of the older population with problems with alcohol are late-onset drinkers.)

3. the intermittent drinker. These persons are periodic binge drinkers but otherwise abstain or drink only moderately. This is a smaller sub-set.

The causes, implications and treatment needs for each of these three categories are clearly different.

**Services and Programs**

The US has traditionally been concerned with alcohol abuse because of the resulting costs to the nation of violence, physical abuse and loss of economic productivity in the workplace. Older persons who abuse alcohol may not have the same opportunities as younger persons to impact on society in these ways. However the costs to health care as well as to the individual's well being is great and for these reasons, if no other, the need for programs and services is justified. However there are a paucity of programs and the service agencies that end up providing assistance to the older person with alcohol problems are usually agencies that have been established to serve the older person or the abuser of alcohol but not both. (Pruzinsky, 1987.) Neither the aging service system nor the substance abuse service providers recognize the older person who abuses alcohol as their obvious clients and hence the older individual may "fall
between the cracks."

The good news is that in spite of the prevailing myths that older persons cannot change, the literature and experience in the field, show that older persons complete treatment more often and require shorter length programs, (Gurnack & Thomas, 1989), than their younger counterparts. Older persons also respond better to treatment which includes peer support and peer group treatment modalities. (Zimberg, 1985.) In addition, the older person interacts with the health care system to a greater degree than younger persons so that, with education of health care professionals, there is an increased chance that symptoms of alcohol abuse (especially among the late-onset drinker) may be detected and treated at an early stage.

Service programs, utilizing group peer support, and counseling that views the abuse of alcohol as a symptom of underlying needs related to aging has proven successful. There is an increasing number of programs expressively for the older person with problems with alcohol in NYC but still far too few. Programs may be outpatient clinics such as the Elderly Alcoholics Component of the Bronx-Lebanon Hospital Center or Our Lady of Mercy Hospital; hospital based as at Coney Island Hospital Center; or located within long term care facilities. The NYC Health and Hospitals Corporation (HHC) is developing ways within its five long term care facilities to deal with substance abuse among the residents.

However the number of existing programs for this population is small and there are few programs for the older person living
in the community. The NYC Housing Authority serves approximately 66,000 persons over the age of 62 years in its 450 housing units and while there are no conclusive numbers, it is estimated that a minimum of 5% of these older persons (3,300) have problems with alcohol abuse.

Recommendations

While it is clear that the need exists for increased services that target the older person with substance abuse problems specifically, there are a number of other activities and strategies that can be implemented with a minimum of costs. Other speakers today will be addressing service needs and I will therefore limit my recommendations to the area of education and public awareness. In this regard the City Council is applauded for the resolution of last March that has resulted in today's hearing. This event in itself is a major step in increasing general understanding and acknowledgement of the extent of substance abuse among the city's older population.

Education for Providers.

Health and social service professionals in the substance abuse service system need to know about aging and their counterparts in the aging service system need to know about alcohol abuse and the proven methods of effective treatment. Both sets of professionals need to be knowledgeable about the special characteristics of aging and alcohol abuse. Such education will result in enhanced diagnosis, appropriate referrals and an
increase in effective treatment.

Specific Recommendations:

1. Official recognition by the appropriate City agencies - the NYC Dept. for Aging (NYCDFTA) and the NYC Dept. for Mental Health, Mental Retardation and Alcoholism Services (NYCDMHMR & AS) and the NYC Housing Authority (NYCHA) - that the problem and service needs exist. Memorandums of understanding between the departments regarding a) the need for joint planning and policy and b) a shared educational response to the staff of the departments' contractual agencies.

2. Sponsorship and in-kind and/or financial support by New York City government for educational conferences, seminars, and forums concerning older persons and alcohol abuse. This will raise general awareness and sensitivity among both the general public and health and social service workers.

3. Credentialed Alcoholism Counselor (CAC). In order to become a recognized alcohol counselor, an individual must hold a certificate in alcohol counseling, awarded after participation in an educational program on alcoholism and alcohol abuse. Several colleges and educational institutions offer the required course leading to a certificate. It is recommended that content concerning the older person and substance abuse be integrated into the certificate curriculum and that currently credentialed counselors be required to participate in continuing education on the topic.

4. Educational requirements for staff working in HHC
facilities. Discussion with the NYS Department of Health regarding similar educational requirements for staff working in health care facilities that are licensed by the NYS Department of Health. The requirement should apply to home health aides, nurses' aides and other paraprofessionals as well as to physicians, administrators, nurses and other health care professionals.

5. Encouragement of coalitions, for purposes of mutual education, between the various service systems - housing, aging, mental health, health. Existing coalitions such as interagency councils, borough and district groups to be urged/advised by the NY City Council to include a focus on this issue within their meetings.

Education for the Public

Education of the general public and an increase in awareness can alert older persons, family members and friends to the problems of substance abuse and will, hopefully, lead to increased identification and referral for assistance and treatment.

Specific Recommendations

1. The City Council with the relevant City Departments to initiate a public, informational campaign using subway advertisements, posters, and public broadcasting announcements. (The Interagency Council on Aging, Alcohol and Other Substances holds an interest in this outreach but lacks access to the needed
resources to effect such a campaign.)

2. A citywide art contest/competition for older persons on the theme of Old Age and Substance Abuse. Winning entries to be displayed or performed in a public arena, city museum or gallery, or a corporate center.

3. Information on available services, facts about the issue, to be available to the public in legislators' offices and be distributed to libraries, community centers, health clinics and physician's offices.

There are other means to reach the public and the providers and the recommendations suggested here are by no means inclusive. Many creative and effective ways can be developed. The main objective is to raise awareness and increase understanding. This may not solve the problems of substance abuse and our older population but education is cost effective and a necessary first step.

Thank you for providing this opportunity to speak before you today.

MJ MELLOR
1/95
References


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Testimony before the Committee on Aging and Subcommittee on Mental Health, Mental Retardation, Alcoholism, and Drug Abuse Services of the New York City Council, regarding Drug and Alcohol Abuse among the elderly in New York City.

My name is Dr. Sheldon Zimberg. I am a Clinical Professor of Psychiatry at Columbia University College of Physicians and Surgeons. I would like to commend the New York City Council for having a hearing on a much neglected issue.

In 1966, I was Chief of Community Psychiatry at Harlem Hospital where I developed the alcoholism program. At that time the only other alcoholism clinic was at Kings County Hospital in Brooklyn. In 1967, I began the geriatric psycho-social treatment program at Harlem Hospital. This program included some elderly alcoholics. I had a unique opportunity to treat younger alcoholics as well as elderly alcoholics at the same time. It soon became apparent that the elderly alcoholics were responding much more quickly than the younger patients and the treatment used with them was not alcoholism specific, but rather directed at the stresses of aging.

In the late 1960's in New York City there were only two alcoholism clinics, and over the years there has been a great increase in alcoholism treatment services, both inpatient and outpatient. In contrast, there has been very few programs for elderly alcoholics developed during this time, in spite of the
fact that there is a relatively high rate of alcoholism among the elderly.

The main substance abuse problem in the elderly are the benzodiazepine tranquilizers such as Valium, Xanax, Halcion, etc. and various pain killers. Substance abuse often exists with alcohol abuse. Elderly alcoholism occurs in an early onset group (long history) and a late onset group (starts late in life).

Some recent reports in the literature showed 14% of the elderly seen in an emergency room were alcoholics and in an article in the Journal of the American Medical Association the rate of admission of the elderly Medicare recipients for alcohol related medical conditions was about equal to that for heart attacks. The aging population is growing and yet this treatable condition continues to be ignored.

Let me briefly describe what aging specific approach to treating elderly alcoholics consists. It involves a group of elderly patients with various psychiatric conditions, some of whom have alcoholism and can include those with moderate degrees of dementia. There must be a sophisticated psychiatric diagnosis. Medical problems must also be addressed, but not necessarily taken care of by the group program. Psychiatric medications are used judiciously particularly anti-depressants. The group utilizes a self help focus where patients are called upon to help each other with problem solving, thus enhancing their self esteem. Interventions can be made by the staff in areas outside the group to reduce sources of stress. The staffing for these groups consisted of a psychiatrist, a psychiatric nurse, or a social worker as co-therapist and one aide or volunteer who can visit patients at home. The group lasts 1-1 1/2 hours. At one hospital group, I trained selected home attendants to make observations about patients behavior at home and to assist in the patients in attending medical and agency appointments.
In the aging specific model alcoholism is only one of the problems addressed along with the other stresses of aging such as bereavement, declining physical health, retirement from work, etc. This approach has been effective in both the early onset elderly alcoholics and the late onset elderly alcoholics.

I started such groups in several general hospitals psychiatric clinics, a suburban community mental health center, a nursing home, a senior citizen center in Manhattan, and supervised a young geriatric psychiatrist in successfully developing this model in a psychiatric clinic at St. Lukes Hospital. Thus, this approach can be applied successfully in a variety of settings and be taught to others.

The effectiveness of the aging specific approach for alcoholism in the elderly was reported in England in the 1970’s and in recent years by several clinicians in this country. Thus, it is reproducible, easily learned and effective.

Therefore, why hasn’t this approach been widely applied? Several barriers exist. There has been some difficulty in identifying elderly alcoholics since screening instruments are designed for young alcoholics and signs of alcoholism are easily confused with dementia. The aging system has little knowledge of alcoholism. The alcoholism system’s alcohol specific model where the alcoholism is the major focus of treatment is often ineffective in the elderly. Another reason is agism, a form of discrimination, that assumes the elderly can not change and should be infantilized. This is embodied in the often heard phrase "why should you take his bottle away, that’s all he has left." The reality is that he or she drinks mainly because that is all they have left. An effective aging approach provides reasons for living, treatment of depression, and opportunities to help oneself and help others and thus provide meaning to one’s life, which we all need.
What can be done to rectify the problems of the many elderly alcoholics who live in our city and are not receiving treatment? Do we need more programs or a different system to identify and treat elderly alcoholics? I don't believe that new programs or systems are necessary. What is needed is that staff and agencies serving the elderly be trained to recognize alcoholism in their clients using newly developed screening approaches (see attached Geriatric Michigan Alcoholism Screening Test) for alcoholism in elderly patients. The clinical staff in mental health and alcoholism programs should be trained in this aging specific approach and develop collaborative relationships with agencies serving the elderly. Regulatory authorities should require treatment programs specifically for the elderly people within existing treatment services and to reach out to the aging system for referrals.

The elderly are the most responsive group of people that I have treated in the 33 years of psychiatric practice. This fact should be brought to the attention of every health care professional who works with the elderly in order to overcome the attitude of ageism. The effective model of treatment described can change the current situation of avoidance and neglect of the elderly alcoholics so that many people can experience improved functioning, stopping alcohol and addictive drug use and giving an incentive to live with hope and dignity to many elderly individuals.
Michigan Alcoholism Screening Test - Geriatric Version (MAST-G) © The Regents of the University of Michigan, 1991

1. After drinking have you ever noticed an increase in your heart rate or beating in your chest? __ Yes (1) __ No (0) 

2. When talking with others, do you ever underestimate how much you actually drink? __ __ __

3. Does alcohol make you sleepy so that you often fall asleep in your chair? __ __ __

4. After a few drinks, have you sometimes not eaten or been able to skip a meal because you didn't feel hungry? __ __ __

5. Does having a few drinks help decrease your shakiness or tremors? __ __ __

6. Does alcohol sometimes make it hard for you to remember parts of the day or night? __ __ __

7. Do you have rules for yourself that you won't drink before a certain time of the day? __ __ __

8. Have you lost interest in hobbies or activities you used to enjoy? __ __ __

9. When you wake up in the morning, do you ever have trouble remembering part of the night before? __ __ __

10. Does having a drink help you sleep? __ __ __

11. Do you hide your alcohol bottles from family members? __ __ __

12. After a social gathering, have you ever felt embarrassed because you drank too much? __ __ __

13. Have you ever been concerned that drinking might be harmful to your health? __ __ __

14. Do you like to end an evening with a night cap? __ __ __

15. Did you find your drinking increased after someone close to you died? __ __ __

16. In general, would you prefer to have a few drinks at home rather than go out to social events? __ __ __

17. Are you drinking more now than in the past? __ __ __

18. Do you usually take a drink to relax or calm your nerves? __ __ __

19. Do you drink to take your mind off your problems? __ __ __

20. Have you ever increased your drinking after experiencing a loss in your life? __ __ __

21. Do you sometimes drive when you have had too much to drink? __ __ __

22. Has a doctor or nurse ever said they were worried or concerned about your drinking? __ __ __

23. Have you ever made rules to manage your drinking? __ __ __

24. When you feel lonely does having a drink help? __ __ __

Scoring: 5 or more "yes" responses indicative of alcohol problem.
For further information, contact Frederic Blow, Ph.D., at University of Michigan Alcohol Research Center, 400 E. Eisenhower Pkwy, Suite A., Ann Arbor, MI 48104, 313/998-7952.
Alcoholism in the elderly

A serious but solvable problem

Preview questions

How prevalent is alcoholism in the elderly?

Why is diagnosis of alcoholism more difficult in the elderly than in younger persons?

What type of treatment is most effective for elderly alcoholics?

Sheldon Zimberg, MD

Alcoholism has been considered an insignificant problem among the elderly. It has been believed that persons with alcoholism in their younger years give up problem drinking as they age and that the elderly generally do not abuse alcohol.

Recent information, however, suggests that alcoholism in the elderly is a serious problem that has largely been ignored. Community-based studies have provided significant evidence. For example, in the Washington Heights area of Manhattan the prevalence of alcoholism was found to be 22/1,000 in the age-group 65 to 74 and 105/1,000 in elderly widowers, whereas the figure for the overall population of the same area was 19/1,000. Another study showed that women aged 60 and over had the highest percentage of alcoholism among United Automobile Workers aged 21 and over in the Baltimore metropolitan area.

In hospital admission studies, 18% to 56% of elderly medical admissions and 23% of psychiatric admissions were found to be alcoholic. Of persons over age 60 who were arrested in San Francisco for minor crimes, 82% were charged with public drunkenness. A medical home-care program and a geriatric psychiatry outpatient program noted that 13% and 12%, respectively, of patients treated were alcoholic. These statistics are representative of the evidence accumulated from a variety of sources indicating that alcoholism in the elderly is, in fact, a problem of major proportions.

Diagnosis and classification

Because of the established significance of alcoholism in the elderly, diagnosis and classification assume major importance. The alcohol-abuse scale developed by me and shown in table 1 has

continued
Lower alcohol consumption in elderly versus young alcoholics means that alcohol-related medical problems generally are less common in the former.

Table 1. Alcohol-abuse scale based on level of severity

<table>
<thead>
<tr>
<th>Severity level</th>
<th>Drinking frequency</th>
<th>Social problems</th>
<th>Health problems</th>
<th>Legal problems</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. None</td>
<td>Drinking only on occasion, if at all</td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>2. Minimal</td>
<td>Drinking is not conspicuous; occasional intoxications (up to 4/yr)</td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>3. Mild</td>
<td>Intoxications occurring up to 1/mo, although generally limited to evenings and weekends</td>
<td>Some social, family, or occupational impairment related to drinking</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>4. Moderate</td>
<td>Frequent intoxications (up to 1 or 2/wk)</td>
<td>Significant social, family, or occupational impairment</td>
<td>Some suggestive evidence of physical impairment, eg, tremors, frequent accidents, epigastric distress, loss of appetite at times. No history of delirium tremens (DTs), nutritional deficiency, or hospitalization</td>
<td>None</td>
</tr>
<tr>
<td>5. Severe</td>
<td>Almost constant drinking (practically every day)</td>
<td>Severe disruption in social or family relations. Inability to hold steady job, but ability to maintain self on public assistance</td>
<td>History of DTs, cirrhosis, chronic brain syndrome, neuritis, or nutritional deficiency. One or more arrests related to drinking</td>
<td>One or more arrests related to drinking</td>
</tr>
<tr>
<td>6. Extreme</td>
<td>Same as above</td>
<td>Same as above, plus homelessness and/or inability to maintain self on public assistance</td>
<td>Same as above</td>
<td>Same as above</td>
</tr>
</tbody>
</table>

Adapted from Zimberg et al.
Early-onset and late-onset elderly alcoholics respond equally well to appropriate therapeutic intervention.

proved clinically useful in establishing a diagnosis of alcoholism based on level of severity. The scale can be used to measure changes in severity over time due either to spontaneous remission or to treatment. Generally, there are fewer signs and symptoms of alcoholism and fewer physical sequelae in the elderly. Therefore, the severity rating is most likely to be level 3, in contrast to levels 4 to 6 as found in younger alcoholics. The basis of this difference is the tendency of elderly persons to consume smaller quantities of alcohol, possibly because they cannot metabolize it as readily as younger persons. This lower consumption means that elderly alcoholics have fewer acute alcohol-related medical problems.

Several factors make diagnosis of alcoholism more difficult in the elderly than in younger persons. As mentioned, the manifestations of alcoholism are more subtle in the elderly; the problems are primarily social rather than medical, and greater effort is required to elicit these social problems. In addition, the source of certain mental and behavioral problems in the elderly may not be readily apparent without considering the effects of alcohol. For example, organic brain syndromes can be exacerbated, even by the smaller quantities the elderly consume. Moreover, the elderly often are on medication regimens, and associated use of alcohol can produce states of confusion that are out of proportion to the amount of alcohol consumed.

A number of authors have classified elderly alcoholics into two groups: early-onset alcoholics, who represent about two thirds of this population, and late-onset alcoholics, who represent about one third. Early-onset alcoholics have a long-standing history of alcoholism that continues into later life, although the severity is somewhat attenuated from their younger years. This group seems to have personality characteristics similar to those of younger alcoholics. In the late-onset group, alcoholism develops in later life, usually in response to stresses of aging such as depression, bereavement, retirement, loneliness, marital stress, and physical illness. Although different factors may be associated with the initial development of alcoholism in these two groups, it has been the experience of clinicians that both groups respond equally well to appropriate therapeutic intervention.

Treatment
Although professional awareness of alcoholism in the elderly is still developing, there have been ear- continued on page 171
The stresses of aging can prolong existing alcoholism or cause alcoholism in those who had no previous drinking problem.

...ly reports of successful intervention. Drollier, in England, visited and treated seven elderly alcoholics in their homes; he found that in addition to medical and supportive treatment, social therapy was the most beneficial. Rosin and Glatt, reporting on the treatment of 103 elderly alcoholics, noted that environmental manipulation and medical services, along with day hospital care and home visiting by staff and neighbors, were the most beneficial.

In my experience in an outpatient geriatric psychiatric program and as consultant to a medical home-care program and to a nursing home, I found that group therapy, socialization, and antidepressant medication were effective in eliminating alcohol abuse in many elderly patients. Both early-onset and late-onset alcoholics responded equally well to these psychosocial interventions, which suggests common etiologic factors in the two groups. The use of disulfiram (Antabuse) or referral to Alcoholics Anonymous or alcoholism treatment programs, which is often required in younger alcoholics, was not necessary in these elderly patients.

There is a spontaneous remission rate in alcoholism. As people get older, they tend to drink less or stop drinking altogether; their alcoholism "burns out." However, some alcoholics tend to drink abusively in their later years in response to the stresses of aging. These stresses can prolong existing alcoholism or cause alcoholism in those who had no previous drinking problem. Therefore, the psychosocial treatment approach is helpful for both early-onset and late-onset alcoholics.

Referral of the elderly to alcoholism treatment programs would seem inappropriate for two reasons. First, the absence of physical distress associated with alcoholism in most elderly alcoholics leads to their reluctance to use specialized alcoholism treatment programs. Chronic problems such as cirrhosis of the liver or peptic ulcer may be present in the elderly, but the need for detoxification and for treatment of alcohol withdrawal manifestations is quite rare. (Also, although denial exists in elderly alcoholics as well as in younger ones, the confrontation required to get...
Sociopsychologic Intervention can significantly reduce alcoholism and other behavioral disorders in the elderly both in community and in institutional settings.

Younger alcoholics to recognize their alcoholism has not been found necessary in the elderly.

Second, as mentioned, treatment approaches directed at the social and psychologic stresses associated with aging are the most successful. The treatments of choice are group socialization, social casework, family casework, use of antidepressant medication for the clinically depressed, and medical care for physical problems. Treatment intervention is most effective when delivered through facilities serving the aged, such as senior citizen programs; outpatient geriatric, medical, or psychiatric programs; nursing homes; or home-care programs.

The Queen Nursing Home in Minneapolis deals exclusively with elderly alcoholics, apparently with some success. However, such specialized programs may not be the most effective way of delivering services to the elderly alcoholic on a large scale.

The problems associated with providing health care services to the elderly in general apply to services for elderly alcoholics as well. Many patients are unwilling to participate in outpatient programs or are unwilling or unable to leave their home to do so. Therefore, the delivery of comprehensive services must include outreach and casefinding as well as effective home-care programs. For patients who are unwilling to participate in group activities, an effort must be made to learn their particulars interests and areas of competence that might be used to catalyze involvement in some aspect of a program.

Use of the therapeutic community
In an institutional setting, such as a nursing home, where alcoholism has been noted to be a problem along with other behavioral disorders, applying the principles of the therapeutic community can effectively improve patient management. This approach involves setting up patient-staff groups to discuss problems, giving patients greater autonomy in making decisions about their needs, and establishing a patient government that can be an advocate for patient interests and assist in the management of patient problems.

In a county-operated nursing home in suburban New York, I provided consultation to nurses who were effectively able to utilize the principles and practices of the therapeutic community. Those behavioral problems, including alcoholism, that had been frequent were all eliminated. Patients participated in many activities and became involved in establishing community college courses at the nursing home. Such sociopsychologic interventions can significantly reduce alcoholism and other behavioral disorders in the elderly in the community as well as in institutional settings.

Summary
Alcoholism is a more common problem in the elderly than has been recognized. Manifestations are more subtle than in younger alcoholics, and problems are primarily social rather than medical. Treatment approaches directed at the psychosocial stresses associated with aging are the most successful. The principles of the therapeutic community have also been effective in eliminating alcoholism and other behavioral disorders in elderly alcoholics. PGM

Office address: Sheldon Zimbler, M.D. Joint Diseases, North General Hospital, 1919 Madison Ave, New York, NY 10035.
Self-assessment test

Select the best answer for each of the following. Answers are given on page 230.

1. More physical sequelae of alcoholism generally occur in the elderly than in younger alcoholics.
   a. True  
   b. False

2. In late-onset alcoholics
   a. Personality characteristics are similar to those in younger alcoholics
   b. Alcoholism develops in response to the stresses of aging
   c. Both a and b
   d. Neither a nor b

3. Which of the following forms of therapy has/have proven beneficial in the treatment of the elderly alcoholic?
   1. Environmental manipulation
   2. Socialization
   3. Group therapy
   4. Antidepressant medication
   a. 1, 2  
   b. 1, 3  
   c. 2, 4

4. The need for detoxification and for treatment of alcohol withdrawal manifestations is quite rare in the elderly alcoholic.
   a. True  
   b. False

5. Treatment interventions for the elderly alcoholic are most effective when delivered through
   a. Alcoholism treatment programs
   b. Alcoholics Anonymous
   c. Facilities serving the aged
   d. Inpatient hospitalization programs

6. The delivery of comprehensive services to the elderly alcoholic must include
   a. Outreach services  
   b. Case-finding services  
   c. Home-care programs  
   d. All of these

7. Characteristics of moderate alcohol abuse include
   1. Intoxication one or two times/month
   2. Significant impairment in social functioning
   3. Mild nutritional deficiency
   4. Some evidence of physical impairment in social functioning
   a. 1, 2  
   b. 1, 3  
   c. 2, 4

References

15. Zimbarg B. The elderly alcoholic: a psychosocial perspective. Arch Gen Psychiatry 1974;31:921-9
Information on Alcoholics Anonymous

FOR ANYONE NEW COMING TO A.A.,
FOR ANYONE REFERRING PEOPLE TO A.A.

This information is both for people who may have a drinking problem and for those in contact with people who have, or are suspected of having, a problem. Most of the information is available in more detail in literature published by A.A. World Services, Inc. A list of recommended pamphlets and Guidelines is given on the other side of this sheet. This tells what to expect from Alcoholics Anonymous. It describes what A.A. is, what A.A. does, and what A.A. does not do.

WHAT IS A.A.?

Alcoholics Anonymous is an international fellowship of men and women who have had a drinking problem. It is nonprofessional, self-supporting, nondenominational, multiracial, apolitical, and available almost everywhere. There are no age or education requirements. Membership is open to anyone who wants to do something about his or her drinking problem.

WHAT DOES A.A. DO?

1. A.A. members share their experience with anyone seeking help with a drinking problem; they give person-to-person service or "sponsorship" to the alcoholic coming to A.A. from any source.
2. The A.A. program, set forth in our Twelve Steps, offers the alcoholic a way to develop a satisfying life without alcohol.
3. This program is discussed at A.A. group meetings.
   a. Open speaker meetings—open to alcoholics and nonalcoholics. (Attendance at an open A.A. meeting is the best way to learn what A.A. is, what it does, and what it does not do.) At speaker meetings, A.A. members "tell their stories." They describe their experiences with alcohol, how they came to A.A., and how their lives have changed as a result of A.A.
   b. Open discussion meetings—one member speaks briefly about his or her drinking experience, and then leads a discussion on A.A. recovery or any drinking-related problem anyone brings up.
      (Closed meetings are for A.A.s or anyone who may have a drinking problem.)
   c. Closed discussion meetings—conducted just as open discussions are, but for alcoholics or prospective A.A.s only.
   d. Step meetings (usually closed)—discussion of one of the Twelve Steps.
   e. A.A. members also take meetings into correctional and treatment facilities.
   f. A.A. members may be asked to conduct the informational meetings about A.A. as a part of A.S.A.P. (Alcohol Safety Action Project) and D.W.I. (Driving While Intoxicated) programs. These meetings about A.A. are not regular A.A. group meetings.

MEMBERS FROM COURT PROGRAMS AND TREATMENT FACILITIES

In the last years, A.A. groups have welcomed many new members from court programs and treatment facilities. Some have come to A.A. voluntarily; others, under a degree of pressure. In our pamphlet "How A.A. Members Cooperate," the following appears:

   We cannot discriminate against any prospective A.A. member, even if he or she comes to us under pressure from a court, an employer, or any other agency.

   Although the strength of our program lies in the voluntary nature of membership in A.A., many of us first attended meetings because we were forced to, either by someone else or by inner discomfort. But continual exposure to A.A. educated us to the true nature of the illness... Who made the referral to A.A. is not what A.A. is interested in. It is the problem drinker who is our concern... We cannot predict who will recover, nor have we the authority to decide how recovery should be sought by any other alcoholic.

PROOF OF ATTENDANCE AT MEETINGS

Sometimes, courts ask for proof of attendance at A.A. meetings.

Some groups, with the consent of the prospective member, have the A.A. group secretary sign or initial a slip that has been furnished by the court together with a self-addressed court envelope. The referred person supplies identification and mails the slip back to the court as proof of attendance.

Other groups cooperate in different ways. There is no set procedure. The nature and extent of any group's involvement in this process is entirely up to the individual group.

This proof of attendance at meetings is not part of A.A.'s procedure. Each group is autonomous and has the right to choose whether or not to sign court slips. In some areas the attendees report on themselves, at the request of the referring agency, and thus alleviate breaking A.A. members' anonymity.
THE NONALCOHOLIC ADDICT

Many treatment centers today combine alcoholism and drug addiction under "substance abuse" or "chemical dependence." Patients (both alcoholic and nonalcoholic) are introduced to A.A. and encouraged to attend A.A. meetings when they leave. As stated earlier, anyone may attend open A.A. meetings. But only those with a drinking problem may attend closed meetings or become A.A. members. People with problems other than alcoholism are eligible for A.A. membership only if they have a drinking problem.

Dr. Vincent Dole, a pioneer in methadone treatment for heroin addicts and for several years a trustee on the General Service Board of A.A., made the following statement: "The source of strength in A.A. is its single-mindedness. The mission of A.A. is to help alcoholics. A.A. limits what it is demanding of itself and its associates, and its success lies in its limited target. To believe that the process that is successful in one line guarantees success for another would be a very serious mistake." Consequently, we welcome the opportunity to share A.A. experience with those who would like to develop Twelve Step/Twelve Tradition programs for the nonalcoholic addict by using A.A. methods.

WHAT A.A. DOES NOT DO

1. Furnish initial motivation for alcoholics to recover
2. Solicit members
3. Engage in or sponsor research
4. Keep attendance records or case histories
5. Join "councils" of social agencies
6. Follow up or try to control its members
7. Make medical or psychological diagnoses or prognoses
8. Provide drying-out or nursing services, hospitalization, drugs, or any medical or psychiatric treatment
9. Offer religious services
10. Engage in education about alcohol
11. Provide housing, food, clothing, jobs, money, or any other welfare or social services
12. Provide domestic or vocational counseling
13. Accept any money for its services, or any contributions from non-A.A. sources
14. Provide letters of reference to parole boards, lawyers, court officials

CONCLUSION

The primary purpose of A.A. is to carry our message of recovery to the alcoholic seeking help. Almost every alcoholism treatment tries to help the alcoholic maintain sobriety. Regardless of the road we follow, we all head for the same destination, recovery of the alcoholic person. Together, we can do what none of us could accomplish alone.

We can serve as a source of personal experience and be an ongoing support system for recovering alcoholics.

RECOMMENDED MATERIAL AVAILABLE FROM A.A. WORLD SERVICES, INC.

Pamphlets:
"A Member's-Eye View of Alcoholics Anonymous"
"How A.A. Members Cooperate"
"If You Are a Professional, A.A. Wants to Work With You"
"Problems Other Than Alcohol"
"Understanding Anonymity"

"Let's Be Friendly With Our Friends"
"Is A.A. For You?"
"A.A. in Treatment Facilities"
"A.A. and Employee Assistance Programs"
"A.A. As a Resource For Health Care Professional"

Guidelines:
For A.A. Members Employed in the Alcoholism Field
Forming Local Committees on Cooperation With the Professional Community
Public Information
Cooperating With Court, A.S.A.P., and Similar Programs

Videos:
Alcoholics Anonymous—An Inside View
Young People and A.A.
Hope: Alcoholics Anonymous
A.A. — Rap with Us
It Sure Beats Sitting in a Cell
Chapter 5—How It Works (American Sign Language)
Big Book Alcoholics Anonymous (American Sign Language)

For copies of this page, or a catalog of our literature write to:
A.A. World Services, Inc.
Box 459
Grand Central Station
New York, NY 10163
Senior Centers
CB #8 Queens

Senior Citizen Center
Briarwood Jewish Center
139-06 86 Ave.
BRIARWOOD, NY 11435

Fresh Meadows Senior Center
Christ Lutheran Church
73rd Ave. & 180th St.
FRESH MEADOWS, NY 11365

Golden Age Club of
Queen of Peace
141-36 77th Ave
FLUSHING NY 11367

Golden Ring Club, 3rd Housing
Electchester Senior Citizens
65-52 100th St
FLUSHING NY 11365

Golden Age Club of
K.G. Jewish Center
71-25 Main St
FLUSHING NY 11367

Director
Hillcrest Senior Center
168-01B Hillside Ave.
JAMAICA, NY 11432

Hillcrest Jewish Center
Senior Group
183-02 Union Tpke
FLUSHING NY 11366

Director
Hilltop Senior Citizens
87-56 Francis Lewis Blvd
JAMAICA NY 11427

Holliswood Jewish Center
Seniors Club
86-25 Francis Lewis Blvd
JAMAICA NY 11427

Director
Local 3 IBEW Retirees Assoc.
158-11 Jewel Ave
FLUSHING NY 11365
Director
Pomonok Senior Center
67-09 KISSENA BLVD
FLUSHING NY 11367

Director
Q. Jewish Community Council
114-1B QUEENS BLVD
FLUSHING NY 11375

Young Israel of Queens Valley
Senior Center
141-55 77TH AVE
FLUSHING NY 11367
Hospitals

Director
Molliswood Hospital
87-37 Palermo St.
MOLLI, NY 11423

Director
St. Joseph's Hospital
158-40 79th Ave.
FLUSHING, NY 11366

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