



## CHAPTER 5: TREATMENT AND INTERVENTION

### Impact of Demographic Changes on Substance Abuse Treatment Systems

**Kathleen J. Farkas and Laurie Drabble**

- ◆ Expected changes in the age structure of the U. S. population over the next 15 to 20 years will have an impact on the substance abuse treatment system.
- ◆ Social workers and other substance abuse treatment professionals must develop appropriate treatment skills and effective treatment approaches to address older adults who experience alcohol and other drug misuse, abuse, and dependence.

A number of older adults in need of treatment today are not receiving care because of the failure of professionals to recognize the problem, the reluctance of older individuals and families to access substance abuse treatment, and/or the lack of insurance or funds to pay for treatment (U.S. Department of Health and Human Services, 1998). Models developed from the National Household Survey on Drug Abuse indicate that the number of adults aged 50+ in need of treatment will increase from 1.7 million in 2000-2001 to 4.4 million in 2020 (Gfoerer, Penne, Pemberton, & Folsom, 2003; Office of Applied Studies, 2005). The cohorts of aging “baby boomers” (those born between 1946 and 1964) who have used and or abused alcohol and other drugs throughout life are expected to create a “demographic tsunami” for substance abuse and mental health treatment systems (Bartels, 2006).

Satre, Mertens, Areán, and Weisner (2003) reported that the older adults in treatment programs (aged 55+) had higher rates of alcohol dependence, lower rates of drug dependence, and lower psychiatric symptoms compared to the younger adults (40-54 and 18-39) in treatment. Differences in baseline characteristics may also influence treatment retention and outcomes. In a study of male veterans, the older men had similar alcohol consumption and dependence symptoms, but had fewer alcohol-related problems and fewer symptoms of psychiatric distress compared to younger men (Lemke & Moos, 2003).

## Substance Abuse Treatment Use Among Older Adults

- ◆ Substance abuse treatment facilities have always provided care to older adults, but the majority of people admitted for treatment have been younger than 50.

In 2001, 143,900 persons admitted for treatment were aged 50 and older (8%); by 2005 184,400 were aged 50 or older and represented 10% of all those admitted (Substance Abuse and Mental Health Services Administration, 2007).

The Treatment Episode Data Set (TEDS) provides a description of persons older than 50 across the U.S. among three types of service treatment settings. TEDS data can be analyzed by specific age groups: 50 to 54, 55 to 59, 60 to 64, 65 to 69, and 70 and older. Among older adults, those admitted for treatment were more likely to be younger than older: 58% were between 50 and 54, 25% were between 55 and 59, and 17% were aged 60 and older.

- ◆ Proportion of White persons admitted increased by age; the proportion of Blacks decreased by age.
- ◆ Alcohol was the most frequently reported drug of choice, and opiates were the second most frequently reported drug of choice among those older than 50.
- ◆ Alcohol was the primary substance for those aged 65-69 and 70+.
- ◆ Opiates were most frequently the drug of choice for persons aged 50-54 and 55-59. These groups also had the highest proportion of admissions for cocaine, marijuana, and stimulants.
- ◆ Younger persons admitted tended to report more extensive histories of substance abuse treatment than older ones did; 15% to 20% of the groups aged 50 to 64 had had five or more prior treatments; 5% to 7% of the groups aged 65+ had had five or more prior treatments.
- ◆ Most older persons admitted were treated in ambulatory settings: 55% of the younger groups (aged 50 to 54, 55 to 59, and 60 to 64) were in ambulatory settings, and 61% to 63% of the older groups (aged 65+) were in ambulatory care. Older persons also sought treatment in detoxification and/or rehabilitation settings.
- ◆ Of those admitted for treatment, the oldest group (aged 70+; 31%) was more likely than the youngest group (aged 50-54; 13%) to include veterans.

Older adults in need of substance abuse treatment are not a homogenous group. The TEDS provides a snapshot of the similarities and differences among age cohorts

older than 50 in treatment for substance abuse and offers a glimpse of what changes may be in store (Substance Abuse and Mental Health Services Administration, 2007).

### **Motivational Strategies for Assessment and Treatment**

- ◆ Hanson and Gutheil (2004) applied several types of motivational strategies to social work practice with older adults using alcohol. Their recommendations, while not empirically tested, provide useful information for the substance abuse practitioner interested in improving assessment skills with older adults.
- ◆ Supportive, non-confrontational approaches have been used in age-specific treatment programs for older adults and have been associated with positive outcomes (Blow, Walton, Chermack, Mudd, & Brower, 2000; Kashner, Rodell, Ogden, Guggenheim, & Karson, 1992).

Few empirical studies have addressed the use of motivational interviewing techniques with older adults. However, motivational interviewing has provided a strategy for behavior and attitudinal change in substance abuse treatment (Miller & Rollnick, 2002). Motivational strategies offer professionals a range of stages of change and specific steps to engage clients at each of these stages. In a small study designed to study referral approaches, D'Agostino, Barry, Blow, and Podgorski (2006) found that a multi-dimensional approach involving motivational counseling as one component had greater referral rates to alcohol treatment services. Incorporation of motivational strategies into randomized studies of treatment access and assessment will improve the knowledge base.

### **Substance Abuse Treatment Outcomes for Older Adults**

- ◆ Age-specific treatment programs as well as age-specific components embedded in mixed-aged treatment programs became popular in the early to late 1980s (Dupree, Broskowski, & Schonfeld, 1984) and have continued in use with older populations (U.S. Department of Health and Human Services, 1998).
- ◆ There is a limited, but growing, number of empirical investigations on the outcomes of treatment with older adults (Oslin, Pettinati, & Volpicelli, 2002; Lemke & Moos, 2003a, 2003b; Satre, Mertens, Areán, & Weisner, 2004; Satre, Mertens, & Weisner, 2004; Cummins, Bride, & Rawlins-Shaw, 2006).

The literature provides a number of descriptive studies of programs developed for older adults with alcohol and other drug problems. Outcome studies are important, but often difficult to compare because of differences in age cut-offs, outcome variables, and

treatment components. In many studies, the sample sizes are small and the sites vary between inpatient and outpatient settings, and Veterans Affairs (VA) and community-based treatment.

Lemke and Moos (2002) compared older men (aged 55+) with matched samples of younger (aged 21-39) and middle aged (aged 40-54) men treated in substance abuse programs in the VA system and concluded that older men do as well as younger ones in a mixed-age setting. Initial differences in alcohol consumption, negative consequences of drinking, and psychological symptoms were associated with treatment outcomes. Older men reported drinking less, having fewer social consequences related to alcohol, and having fewer psychological symptoms compared to the younger men.

- ◆ Treatment adherence has been shown to be associated with age; older adults attend more treatment sessions and comply better with medication regimens for alcohol dependence as compared to younger adults (Oslin, Pettinati, & Volpicelli, 2002).

In a randomized, double-blind placebo-controlled efficacy trial of naltrexone for treatment of alcohol dependence, Oslin, Pettinati, and Volpicelli (2002) found that older adults (aged 55 and older) were more likely than younger ones to attend treatment sessions and to take medication as directed. These two variables were associated with less relapse.

Satre, Mertens, Areán, and Weisner (2004) compared 5-year outcomes from a managed care substance abuse treatment program and found age differences in drug dependence at base-line, 30-day abstinence rates, social supports, and treatment retention. The older age group (aged 55-74) was less likely to be drug dependent at baseline and had longer treatment retention than did younger groups (aged 40-54 and 18-39). The older group at the 5-year follow-up was more likely to report that family and friends did not encourage alcohol or drug use, and a larger percentage of the older group reported total abstinence in the past 30 days. In this study, older women were more likely than older or younger men to report 30-day abstinence. In a related study (Satre, Mertens, & Weisner, 2004), a higher percentage of women than of men in the older group (aged 55-77) reported abstinence from alcohol and drugs at the 6-month follow-up from treatment (79% of women vs. 54% of men).

Elder-specific programming is associated with better compliance and outcomes, and most often includes other programmatic components such as individualized treatment planning and motivational strategies. It is unclear if the age requirement is the only active component in these studies or if these other components also contribute (Blow et al., 2000; Oslin, Pettinati, & Volpicelli, 2002).

- ◆ Future research should focus on the interactions between age group and treatment strategy.

Few studies have analyzed any interaction between age group and treatment strategy. In a one study, Rice, Longabaugh, Beattie, and Noel (1993) used random assignment to explore differences between three treatments: 1) extended cognitive behavioral treatment; 2) relationship enhancement; and 3) vocational enhancement. For adults aged 50 and older, extended cognitive behavioral treatment showed the best outcomes in increased percentage of days abstinent and decreased percentage of heavy drinking days. The least favorable treatment outcomes for older adults were associated with vocational enhancement. In another study, Kashner et al. (1992) randomly assigned male veterans in alcohol treatment to mixed-age treatment or age-specific treatment. The age-specific treatment was built around principles of respectful and supportive interactions. Reported abstinence rates were twice as likely in the age-specific group, and the 60+ age group reported the most favorable responses.

- ◆ Outcome studies of treatment for drugs other than alcohol among older adults are limited, but this area of research is increasing.

Studies indicate that older adults can benefit from age-integrated alcohol treatment programs at least as much as younger adults do (Lemke & Moos, 2002; Lemke & Moos, 2003a, 2003b; Lofwall, Brooner, Bigelow, Kindbom, & Strain, 2005). For example, Lofwall and colleagues (2005) compared a group of older (aged 50-60) and younger (aged 25-34) men and women enrolled in an ambulatory opioid maintenance program. In comparison with findings from general population studies, both older and younger people had increased rates of psychiatric and substance abuse or dependence problems and had worse general health. Health status and functioning, however, were worse in the older group than in the younger group. The treatment program did not include age-specific or age-appropriate program components, but the older people showed a strong positive response to the program, as measured by low percentages of opiate-positive urine tests.

- ◆ Future outcome-based research should differentiate between age segregation and age appropriate strategies in determining treatment adherence and program outcomes.
- ◆ Outcome studies should examine interactions between age group and treatment intervention type.
- ◆ Studies of older adults need to include more women and members of racial/ethnic and sexual minority groups to determine the most effective treatments for these groups.

Older adults benefit from alcohol treatment programs (Dupree, Broskowski, & Schoenfeld, 1984; Carstensen, Rychtarik, & Prue, 1985; Kofoed, Tolson, Atkinson, Toth, & Turner, 1987; Kashner, et al., 1992; Rice et al., 1993; Schonfeld et al., 2000; Lemke & Moos, 2003; Blow et al., 2000; Satre et al., 2004) and opiate maintenance programs

(Lofwall et al., 2005). Older women may have more favorable drinking outcomes than older men post treatment (Blow, 2000; Satre, Mertens, & Weisner, 2004). For at-risk older drinkers, an integrated system of care model may improve treatment engagement (Zanjani, Zubritsky, Mullahy, & Oslin, 2006). Case management may be a useful tool to increase treatment engagement among older adults (Atkinson, Misra, Ryan, & Turner 2003; Oslin, Pettinati, & Volpicelli, 2002). Factors including social supports, type of substance dependence, treatment retention, and gender interact with age and may provide insight into the relationship between age and treatment outcome (Satre et al., 2004). Stages of change, treatment readiness and motivational interviewing, concepts that have been adapted in AODA treatment for younger people, have been used in studies of health promotion with older people (Popa, 2005) and are beginning to be used in alcohol treatment studies with older people (Zanjani et al., 2006).

Another important area of research is the study of older adults with alcohol and other drug problems who are not in treatment. Walton, Mudd, Blow, Chermack, and Gomberg (2000) interviewed 78 older adult volunteers who met criteria for alcohol abuse or dependence and re-interviewed 48 of them 3 years later. Results showed that health problems (68%) and doctor recommendations (41%) were most common reasons people changed their drinking habits. Only 11% of the sample resolved their alcohol problems when alcohol consumption and alcohol-related consequences were considered. Consideration of alcohol use and alcohol-related problems as a health issue may provide a fruitful avenue for intervention for older adults. Brief treatment advice, usually provided by a physician or other health care professional has been shown to be an effective intervention to reduce alcohol consumption in older and younger adults (Moyer, Finney, Swearingen, & Vergun, 2002). In a randomized community-based study, Fleming, Manwell, Barry, Adams, and Stauffacher (1999) found that two 10- to 15-minute physician delivered education and counseling sessions decreased alcohol use, binge drinking, and excessive drinking over 12 months. The Screening, Brief Intervention, and Referral to Treatment (SBIRT) initiative of the Substance Abuse and Mental Health Services Administration (SAMHSA) may be an especially useful approach for intervention with older adults, especially if it is integrated within established community care and/or primary health organizations (SAMHSA, 2008).

### **Prevention Efforts**

- ◆ With the expected increases in the population over age 60, there is a renewed interest in prevention efforts in alcohol and other drug use and abuse.

Prevention efforts with older adults are important for several reasons: older adults can be negatively affected by consumption of smaller quantities of alcohol or other drugs; negative consequences of use may not be recognized as associated with use; adverse medication interactions may occur with any amount of alcohol use; medication

mismanagement among older adults is common. Health promotion and health education efforts with older adults should include these issues related to older adults' changing vulnerabilities. However, Blow, Bartels, Brockmann, and Van Citters (2005) reviewed evidence-based practice prevention practices and found no substantive evidence that universal prevention programs for prevention or reduction of alcohol misuse are successful for older adults. These authors echo the support for brief interventions, especially those set in health care settings, as effective tools to reduce alcohol misuse and hazardous drinking. Effective prevention avenues to decrease medication mismanagement include computer-based tools to increase the older person's knowledge about potential drug interactions (Blow et al., 2005). Team efforts including health care professionals both in health care institutions and in the community may prove to be effective. The process of implementing evidence-based practice to prevent substance abuse and mental health problems among older adults requires organizational change and involvement of provider and service delivery systems (Blow, Bartels, Brockmann, & Van Citters, forthcoming).

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## Curriculum Resources

The following resources include recommended key curriculum resources, course readings, and Web resources.

### Recommended Readings:



- Cummings, S., Bride, B., & Rawlins-Shaw, A. (2006). Alcohol abuse treatment for older adults: A review of recent empirical research. *Journal of Evidence-based Social Work*, 3(1), 77-99.
- Cummings and colleagues review treatment studies and provide a discussion of important elements of substance abuse treatment for older people.
- Blow, F. (2000). Treatment of older women with alcohol problems; meeting the challenge for a special population. *Alcohol Clinical and Experimental Research*, 24(8), 1257-1266.  
*This article presents specific issues for working with older women and treatment approaches to address their needs.*
- Blow, F., Bartels, S., Brockmann, L., & Van Citters, A. (2005). *Evidence-based practices for preventing substance abuse and mental health problems in older adults*. Older Americans Substance Abuse and Mental Health Technical Assistance Center: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Prevention. Retrieved on February 28, 2008, from <http://www.samhsa.gov/OlderAdultsTAC>.  
*An excellent and extensive review of a range of evidence-based practices for working with older adults and for the prevention of substance-related problems.*

### Films & Media:



**Brief Alcohol Interventions for Older Adults.** This 21-minute video is an overview of a brief intervention. It is divided into two sections: a PowerPoint presentation with a voice-over explaining what a brief intervention is, what it seeks to accomplish, and the best ways to implement it, followed by a role play of a brief intervention with an older adult, which allow viewers to apply key concepts learned. Availability: Free from [http://preventionpathways.samhsa.gov/res\\_videos.htm](http://preventionpathways.samhsa.gov/res_videos.htm).

## Teaching Module:



### **Older Adults and Alcohol Problems Older Adults and Alcohol Problems (Module 10C of a larger curriculum entitled “Social Work Education for the Prevention and Treatment of Alcohol Use Disorders”)**

This curriculum provided outstanding PowerPoint overheads, notes, and class handouts related to brief intervention and treatment targeted specifically to social work students and professionals. Availability: Free from the National Institute of Alcohol Abuse and Alcoholism (NIAAA). Download from Web site at <http://pubs.niaaa.nih.gov/publications/Social/main.html>.