

CSU, Chico Interdisciplinary Center on Aging Substance Abuse Among Older Adults

Sehrawat Seema: Good morning, we'll just go ahead and get started. It's 9 o'clock and others might join us, but I think it's time and we should just get going. I'm so excited to see, you know, so many people in the room today. Thank you so much for coming. We have been having this—this is the third Coffee Connection that we have organized. I think we have never had these many people attending. So definitely, I'm thinking, you know, this is a topic of interest and you really wanted to come and hear our presenters. So thank you for coming.

I--because I know I see some new faces, so I just thought I'll take few moments to introduce the Center on Aging. I don't know if you have heard about the Interdisciplinary Center on Aging for CSU, Chico. We got established in December 2009 at the University and since then, we have been just trying to do some activities on campus in the community to help raise awareness about aging issues among professionals, among students, among faculty. So that's been our activities since 2009. You know, as a new organization struggles with funding and all those things -- we are in that phase that where we don't have a grant to fund us or fund the activities.

So we have not done things on a major scale, but we have partnered with community organizations and have done some wonderful trainings, like the one on hoarding. You might have attended it last month. We have sponsored that with Passages (older adult resource center), and more than a hundred people were there. So that was very exciting, that we could deliver that information to community professionals, students -- and help the students to help older adults in our community. So that has been really good. We also do a film series on the fourth Wednesday of each month. We are doing the last one on the end of November on sexuality issues among older adults. So it's going to be really interesting. If you have time, please come and, you know, come for that movie. It's from 3:30 to 4:45 and it's--if you have one of these flyers, it will tell you the information. Otherwise, it's here in Colusa 110 on November 30th and it's about "Still Doing it-Challenging the Taboo Around Sexuality in Later Life." So it's going to be fun and we do a small discussion afterwards. So we would [laughter]-- [Inaudible Remark] ...we would love to see you here for that.

So without further ado, I think we should get started with our panel today. As you have seen the sign outside, "Welcome, Substance Abuse among Older Adults". That's the sign said and that I just laughed when I saw that sign [laughs]. And we have great people in our panel today. Kathy (Wendt), who's sitting, you know, on my right hand side. She has been a clinician for over 17 years, working for the County for 17 years in the Alcohol Services Program. So she works for Butte County Behavioral Health. She runs her own practice since 2004 and she's one of the few clinicians in town that works with older adults and that population. So we are really glad that she accepted our invitation and could be here to present on these very important topic. She's also our adjunct faculty for the Social Work Program and teaches some classes for the graduate program in our department.

Sherry Brown works for Skyway House. Sherry is the program director for the outpatient services for Skyway House, has been working in the addiction treatment field for over 11 years. So talk about experience and, you know, the knowledge she has about how drug abuse, alcoholism impact individuals, families and community as a whole. So Sherry will share her experiences with us today and we are really

fortunate that Sherry thought that, you know, it's very important for us to provide services for older adults and started a group for older adults who have problems with alcohol and substance abuse. So if you know anyone, please refer them to Sherry and, you know, they can maybe help them through the group they run.

I would also do a brief presentation in the beginning and where I come from, I hope you all know, I'm the interim director for the Interdisciplinary Center on Aging so I have been running this program. I am a faculty with the Social Work Department. And I have--most of my practice has been in the substance abuse field. That's what I did when I was in India. I ran a treatment facility for over 100 adults. And in any given point of time, we had more than 10 percent that we're over, you know, 50 years of age. I also worked in Columbia, Missouri for a year for a treatment facility. And it was a very small, a modified therapeutic community that we run for homeless population. And we only used to have 6 to 8 individuals in the program. It was a residential program for 6 months, and half of that would be adults who were, you know, in their late 50s. So I have been seeing this problem and the challenge was that we did not have anything specialized for that particular population. With Sherry, you know, intends to do, and they are doing it. So that's our hope that we can maybe give you some information that you can take back home and use it to work for older adults. I don't want to right away jump into the topic of substance abuse, but I thought why not just take 5 minutes and have a discussion about who is an older adult? Do you know the definition or whom do you consider an older adult? Yeah.

Audience member: 65 or more?

Sehrawat Seema: So many-- many times or almost every person, they think that retirement, you know, people usually retire at 65 plus and that's when you know the older adult would start. If you look at the research literature, it's conflicted. They even say 50 plus. So many articles--many journal articles -- will, write about the older adult population and they would say 50. It's in the early spectrum but they still consider it the older adulthood. And if you know, if you have turned 50 already, you must have got something from AARP, right? [Inaudible Remark] [Laughter] Have you--do you--

[Laughter]

[Inaudible Discussion]

Sehrawat Seema: So, yeah. AARP funerals home, they, you know, target you as soon as you turn 50. So the definition of older adult is very blurry. And I have a friend who is in her late 70s and I was at her house yesterday and she showed me a bruise that she got because she fell from her bed at 1 o'clock in the night. And why--what was she doing at 1? Well, she was looking out her bedroom window because she saw a car in her backyard or, you know, they have a church in their backyard. So she saw a car and she was all curious, you know, so she wanted to climb up and see what's going on at 1 in the night. And then she was wearing those silk pajamas and, you know, slipped and fell and her--I think, her side table, her end table, got her and, you know, she had a big bruise. And I said, "But why did you do this?" And she's like, "I don't think that I'm that aged that I can't do all these things anymore." So if you talk to an older adult, they don't think that they are in that age spectrum and that they should be considered old. So the definition of an older adult is very, very blurry and I just thought, you know, I just want to mention that. And in our last film series, we were talking about so who is a baby boomer? And, you know, we all including me, you know, this is the area I work in and I, you know, I had to think about it. So who is a baby boomer? I went and did some research but I want to see if you have an idea who a baby boomer is?

Audience member: Somewhat 45 to 63 years old like that, 1964 or 63?

Sehrawat Seema: Yeah – right on 1946 to 1964. So at a 20-year age range is what we call baby boomers. And if you look at this population, the early spectrum of the baby boomer population, they grew up where, you know, listening to the rock music, they saw the assassination of President Kennedy and all those have impacted their lives a lot. But if you look at the later spectrum, you know, people who were born after 1959, they did not have rock music in their lives, they have not experienced the assassination of President Kennedy and all other things that were happening in that era. So that later spectrum baby boomer population is very different from the early spectrum. And I was reading a baby boomer bulletin and it was--it was talking about, don't lump us together. You know, yes, we are this baby boom generation but our needs are so different. What we experienced in history is so different. Our music taste and things like that are just so different. And the later spectrum of baby boomer, they had more use of illicit drugs in them. So that was getting more prevalent in, you know, the late 1950s or 60s. If you look at 1930s, 40s, there was hardly any trend of alcohol and illicit drugs. So I think it's--it's not right on our part to club the entire spectrum together. So when we are talking about substance abuse among older adults today, I want us to have that perspective in our mind that, you know, yes, we need to provide services but we don't we need to club the whole, you know, baby boom generation together. You want to add something?

Kathy Wendt: No.

Sehrawat Seema: Okay. Let me just give you some brief statistics so you would know what we are talking about in terms of substance abuse among older adults today. Research suggests that the number of older adults needing substance abuse treatment will grow from 1.7 million in 2000 to 4.4 million in 2020, which is more than a 100 percent increase in the number of older adults needing treatment for substance abuse issues. And you know, then you would wonder, why such a huge shift. One, because of there would be more--50 percent more older adults. You know, because the baby boomers are aging. So we are looking at a huge big population of older adult that would need services. And the second is there will be a 70 percent hike in people who are abusing, so they would need treatment. So we are talking about, you know, by 2020, it's just going to hit us. And we do really need to be prepared for services to help this population of adult substance abuse treatment needs. Also, researchers and practitioners are calling substance abuse among older adults as an invisible epidemic. That's what you know, research and practitioners have been referring because you are seeing more and more of older adults either starting late or still continuing what they have been exposed in their early years. And Kathy and Sherry will talk about their experiences of working with this population. But I just thought I would present some statistics.

Also, alcohol and prescription drug problems affect almost 17 percent of older Americans today. So, you know, you talk about 17 percent, you know are abusing prescription drugs or alcohol. And if you look at the hospitalization rate of alcohol-related hospitalizations versus heart attack, it's almost similar. So, you know, talk about cost, medical costs and how a huge impact it's going to be on the medical field and the costs we will need. Also, there are few factors that make you prone to be abusing prescription drugs or alcohol. And research suggests that being a female, you are at a higher risk of maybe abusing alcohol or prescription drugs. Social isolation – that you are socially isolated that might, you know, up your chances of drug use. History of substance abuse or mental health disorder. So you if you have some other, you know, mental health disorder, you might self-medicate yourself so that ups your chances of drug abuse. And also medical exposure to prescription drugs. And, you know, 1 out of 4 older adults are already

taking prescription drugs that are--that have a potential for drug abuse. So they are already exposed. So if they are already exposed, there are chances of more drug abuse or abuse of those prescription medications in this population. So, you know, the problem is huge and then the question is what we are doing today and what can be done, and what some issues are that we need to explore as professionals, as community members, as family members to help this population. And that's what we will talk about now, and I want to hand it over to Kathy.

Kathy Wendt: Thank you. Sherry and I have talked about this that we're--we were [noise], [laughter] classroom kind of setting. So we're [noise]. So we also enjoy more and more of an interactive so any--anytime you want to jump in with a question or anything, please feel free to jump in. Seema brought up an awful lot of issues that, you know, Sherry and I could probably talk for whole hour on each one of those things that Seema was talking about.

Some things that just came to mind as I was listening to her...I was just doing some math. That somebody if you go the lower end of the baby bloomer, someone born in 1946, if they start drinking at 21, by now they've--they've drunk 44 years. And that's something we see a lot in treatment. We have--I have a client who just last week celebrated his 62nd birthday and his one-year sobriety. This is the—he's 62 and this is one year of sobriety he has in all of his whole entire life. And that's something we see a lot. I had a client who had a heroin addiction. He'd been in prison most of his life and he got out of prison when he was 61. And he'd had 3 years "without heroin" in prison which believe it or not, I mean, I think a lot people assume while when you're in prison, you're clean and sober. But there's a lot of availability, a lot of access to drugs and alcohol in prison. And he'd had 3 years clean and sober in prison and then got into treatment, you know, and maintained his clean and sober time at that age but his whole entire life, he'd been since age--I think first time he was in prison, he was 20. So his whole entire life, he'd been in and out of prison because of heroin addiction. And a great guy super, super smart and that--it's those kinds of situations that are particularly sad. Because he really had the intelligence and the vocabulary, etc. He wanted to be a brain surgeon. I mean that's where he started out, that was his idea and that's how far off tracking for how many years. He was off track, you know, from 18 to 63. So we used to kind of tease him that, you know, it's unfortunate that we don't have him as a brain surgeon because he would have been, you know, he would have been brilliant, really.

But that's the kind of things that you--I think you--we don't think about. We don't do the math at how long these people have been using alcohol or drugs. I was looking at just kind of chronologically, somebody back in the 60's, early 70's, pot was the big drug and, you know, a lot of people were smoking pot, drinking? Well, you know, there's always alcohol in the picture, kind of throughout your life. Somebody who's drinking or using or has an addiction, and then the mid 70s through the late 80s, cocaine was the big drug. So of course, it was cocaine and alcohol, so you get those two going at the same time. And then cocaine got too expensive so people started doing meth. We have a lot of meth and people addicted to meth that quit using cocaine, starting using meth cause it was cheaper, you know, unfortunately. And then that leads down the whole path of dealing and manufacturing meth, et cetera. And then--and then you get -- and of course, cocaine is making a big comeback right now. So a lot of younger people, it's almost--I'm watching because I'm a baby boomer. So I'm watching that whole cycle come back again. People that are still out on the streets, they're still going to the bars, still partying. At my age are, you know, are still doing a lot of those drugs and drinking. And then we have a whole new younger crowd coming up that are doing the same kind of thing. So they're downtown in the bars and drinking, and drinking at home. And you know cocaine and meth, of course is a lot more -- club drugs, hallucinogens and stuff that they've got into, so. We're good, this is not our problem, it's going to--we're looking at the older population now and the issues we're going to have in treatment. And we're

going to have those for a long time, because it's not like it's changing. So it's pretty scary to think about, this range of ages of people in treatment that we're going to be working with and our--you know, the generation behind us. Drug and alcohol counselors and therapies are going to be working that same way. So I was just sitting there doing the math, thinking wow -- job security if we we're going to live that long [laughter]. So I guess I would want and before I--before Sherry and I get in to the whole thing, are there particular topics or subjects or issues around elder abuse that you're particularly interested in, that you would want information about? Or should we just--

Audience member: [inaudible]

Kathy Wendt: Everything? Okay [laughter]. Oh man. That's again -- that's a huge issue with older adults right now and with younger adults because they're selling them on the street, so they're pretty accessible for people to use.

Sherry Brown: I'll share on this.

Kathy Wendt: Thank you.

Sherry Brown: My step father just turned 80 today and he's an alcoholic. And a few years ago, it became obvious that I needed to oversee his medical care. So the first thing I did was looked at his pill box, which--oh my God! He was taking like I don't know, it had to be 12, 13 pills? And I didn't see any medical issues that really prompted him taking anything. And as an alcohol and drug counselor, I'm thinking oh, oh! 'Cause he's on Benzodiazepine, he's on Soma, he's on Vicodin, he's on all kinds of blood pressure medication. I'm thinking, that's a cocktail. He can take his meds and drink a couple of beers and overdose. So I took him to another doctor because the experience was the doctor he was seeing just kept on medicating him. He didn't want to deal with him. He knew he was a drunk. He knew he wasn't going to quit drinking. He just kept giving him more medication. So I took him to a different doctor and let the doctor know that he was alcoholic and I wanted him to review the medications. Well the first thing he took him off was the Soma because of the liver damage, and the Vicodin, because he really did need that, he wasn't in pain. He sort of liked the Benzo, so he kept on that. But, you know, what I had to do with him was I had to juggle his medications because he couldn't function anymore during the day. He couldn't--he was sluggish, he couldn't figure it out. Even though he was--nothing had changed, he was drinking every day. The medications -- he was so over medicated, so what I did was all the medic--well, we took him off quite a bit but a couple of medications that cause drowsiness, I switched to night. And that seemed to help. He was able to function again. So, in my experience -- and this was probably when he was 73 -- he was just way too over-medicated. And the doctor knew he was an alcoholic but he was still pushing all these things on him. And he has high blood pressure. There is no other medical issue, you know. He has an ulcer from drinking all his life. But I mean, so he takes Prevacid or something, but he really didn't need all the medications they were giving him. They just kept medicating him. So I think that's a big one -- is that the older adults if they don't have family members overseeing especially if they have substance abuse problem. And then the scary part would be probably the higher-functioning people becoming addicted to the opiate. I know that my mother had a drinking problem and when she stopped that, she started on opiates--prescription opiates, and that worked for her and she was able to stay on those until she died, and not drink. There's a major improvement [laughs].

Kathy Wendt: So Sherry can I ask you, was the--was it the same doctor that was prescribing all those medications or were they different doctors?

Sherry Brown: No I think it was--well, they started out with the same doctor and then I think he went to a different doctor. But it was 2 different doctors but what I--what I realized was not me overseeing anything that, you know, if someone is--if an older adult is viewed as having a substance abuse problem or just having a substance abuse problem, they're just going to medicate them and get rid of them. You know, and that's what they were doing with my step dad. "How are you?" "I'm fine." You know, and then, "Do you have pain?" "Yeah." He didn't have pain. He's giving the Vicodin to his nieces and nephews. I was horrified. So we stopped that. But I mean, it was time for me to step in and start overseeing things. For some people, they don't have family to do that. They continue to drink and continue to take those medications. I think that it's a potential cocktail for them that could lead to--lead to over dose. You know, much less, addiction. But, you know, that's my experienced with that and with the older adult. "My doctor prescribed that; it's okay. You know my doctor prescribed it and I have to take this." They have regiment and they will and--he was really good. He would take everything like he was supposed to. And he didn't need half of it but the doctor prescribed it so he took it. So that's was really scary.

Kathy Wendt: It would never occur to them to break one of the pills, the opiate, in to half and take half of that. Because the doctor prescribes one every 4 hours, so pain or not, that's what they're going to do.

Sherry Brown: Yeah, and one thing--

Kathy Wendt: One every 4 hours.

Audience member:

Sherry Brown: Yeah and he would know not to take it if he didn't have pain, if the bottle said just for PRN, just pain only. "No, the doctors said to take it, so I'll take it."

Audience member: Also doctors, in my experience with my mother, they don't go and look at an elderly person as a person anymore, they see an old person. And I don't think that they must have been be a good one or you have to tell them and advocate for them. For them it's easier just to say they're old, at that age, just take this. As a social worker for adult services -- [inaudible] you might need 15 pills, that's nothing.[inaudible] ...It's crazy--

Sherry Brown: Yeah.

Audience member: As a lay person, I realized this is not good. Then why don't the doctors address that?

Sherry Brown: Yeah.

Kathy Wendt: I think we were--one of the things that we had talked about was that when doctors-- when they get a new patient, they're very diligent, very careful about assessing and asking all the right questions. When you have somebody that has been going the same doctor for a long time, I think they tend to--just like we do as patients and the doctors do -- I think they tend that you have a relationship already. so you just go in, you say--they say, "How are you doing?" "Fine." You know, "Well, you know, I got this back pain." "Oh, let me prescribe something else," without really even saying, "What else are you taking?" or "Are you drinking? Because one of the things that's--and specific to women -- is that doctors will--I don't want to say dismiss, maybe minimize --the issues with depression. Or they won't assess them for substance abuse. and they're quicker to give them, you know, mood stabilizer or an

antianxiety medication or an antidepressant. You know, Valium--Valium and Vicodin, two very common. You know, Xanax, Ativan, Valium and Vicodin -- very common prescriptions for women who present with, "I'm depressed," or "I'm feeling really anxious, I don't want to go out of the house—out of the house anymore." And so, and I think you're right about doctors. Rather than argue with the patients or educate the patients about it. That's where we have to come in. And family members have to come in. Because there's some older adults that are open to education about their prescriptions and some aren't. Because, bottom line, here's a scary part—opiates work. Vicodin, you know, if you have an older person who's kind of depressed and not real active and doesn't want to do anything and he's not motivated to do anything, stays at home, takes her Vicodin. They don't feel guilty anymore. They can sit and watch TV because what--one of the things opiates do is take away that "I got to do this, I got to do that" or "I should be doing this. They can take opiates and go, "I'm fine." So that's the scary part, is that they work a little too well sometimes, I think, for that kind of thing.

Audience member: You know what else is tricky is that - I work as a private practice [inaudible] working with some of these adults. And they come in. and they may have a connection with a doctor that they see regularly -- and I ask them to go back and have a medication evaluation. And then I will ask them if they would me to communicate with their doctor so that we can collaborate. Nine times out of ten, they will say, "No. I'm--we're good" or "I don't like talking to them."

Kathy Wendt: That's right.

Audience member: And, as you know, as you build the relationship there is a trust that [inaudible]. But early on, the best I can do is ask them to go back. You know, I'll look at what's on their sheet and then say, "Okay. Well, it looks like you might have to go back for evaluation." And have [inaudible] I would suggest that the doctor would [laughs], you know, that they'd be practicing without license. So I ended up [inaudible] with that very end. So, yeah, people need to keep going back there. It has been very successful in that people would come back and say, "Yes, the doctor did changed this and that," or "upped that" or "ended that." And so that's the best I can do, that interest us [inaudible]. You know that the full support in cases is that freedom to make choices. And unless I see them as a danger to themselves or to others, it's really--it's a tricky situation to me and I deal with it on a regular basis. So, you know, it's our due diligence -- but at the same time, you're really powerless to make them change. They'd really need to take that on their own. And then with struggles [inaudible] and then I deal with [inaudible] so lots of times they're--that, you know, to make around grief issues. If I can help them with the grief issues, amazingly enough [laughs]. They are really used to -- take a look at their medications. You know, anytime [inaudible]. So that you could get to the issues following that [inaudible].

Kathy Wendt: That's one of the main issues with late-onset drug and alcohol abuse is that grief part.

Audience member: Can you speak more about that Kathy? Because I think I used to [inaudible] when I came in that the women in my side of the family--my maternal side-- I think they definitely had the cocktails, you know. There was that cocktail hour, there was this real ritual -- I'm talking highballs. But they didn't participate too much on that. I have seen the later onset or maybe there was drinking going on that we weren't aware of and that's what I'm also kind of putting together. And then trying to do some intervention, it has been a challenge, you know, in terms of them even going to a counselor, Because I do think it's a grief[inaudible]... but lots of issues that they were masking and they were drinking. And, you know, it's gotten very severe in some parts of my family. And so you're like, what are, how do we implement the treatment, you know, at that point in their lives? But they are older. When you are [inaudible], how did you fix that end?

Kathy Wendt: I wish I had the answer for that. How about that, Sherry [laughs]? Get them into treatment?

Sherry Brown: You know, my experience in having older adults in treatment -- I can say I've had less than a dozen now in 11 years. I had quite a few in residential treatment and probably half stayed. I've had a couple that were in their 70s, later 70s. And they come in around at the same time and--and one just could not connect with the group because it's a substance abuse group. So I have drugs, we talked about drugs too. so the one he left. And the other guy came to me and he said, "You know what? I cannot relate." And so I modified the program for him and he's seen me on a weekly basis and it worked for him. You know, and he was actually able to stays sober. But what I see a lot is the people--I can reach the people with the substance abuse problem if they're in their 50s and 60s. But older than it's usually just alcohol, and I really haven't had the experience with the prescription medications and that alcohol yet because I haven't had too many older adults, you know. It's--

Kathy Wendt: And what the referral resource comes from -- I think that's an important one because a lot of older adults that are referred for treatment, it comes from the hospital Social Worker which, you know, depending on how that approach goes...

Sherry Brown: Yeah.

Kathy Wendt: ...whether or not they do treatment or what level of treatment they do . Because a lot of them have, from long term drug and alcohol abuse, the health issues that come around that. Or legal -- DUIs are big. And, unfortunately, with first DUIs, they might be referred to a DUI school, not really to treatment. When they started--

Sherry Brown: Unless you are different--

Kathy Wendt: --Yeah. When they started doing the high intensity, the people that had multiple DUIs. When they started ordering them to treatment, I saw a big increase in older adults getting treatment. I'm talking, you know, 45 to 55, say, getting more treatment. And although they were extremely resistant, they were also extremely motivated because it was their last chance, yeah. It's go to prison or go to treatment. So they were highly motivated not to go prison because a lot of these people are pretty high functioning. Some of them were retired after having, you know, long employment history and...

Audience member: Sometimes they're very functioning.

Kathy Wendt: Very functioning.

Sherry Brown: Yeah.

Audience member: They've always been able to manage, and [inaudible].

Kathy Wendt: Yeah, and I think as family members -- and that's why I brought these glasses in -- because one of the big myths with the way people drink alcohol is when people will say, "Well, I've had a cocktail hour my whole entire life -- I have one drink at 5 o'clock." Well, okay so that usually ends up being, okay it's close to 5, so it's 4:30. And then it's 4 and then it's 3:30, you know, they retired. So it's earlier and then it becomes, "Well it's afternoon. I'm not drinking in the morning because it's 5 minutes

after 12." So, you know, that start bumps up earlier. And the way they drink -- I brought this because one of the things I ask people and I brought a bunch of pieces of paper -- if you're interested in these -- is people say, "I only have one glass of wine." Well, you can see the different, you know, size of glasses of wine and most people will--that great big one. That's their glass of wine and they might have a couple of glasses of wine. Okay, mom or grandma, are you--how do you buy wine? You buy wine by the bottle, by the case? Well, you know, Costco has those nice boxes of wine. Matter of fact, Seema was joking about naming this--this panel discussion -- the little pink box of wine. A little box of pink wine. Because there's no--particularly with a box of wine, there's not really concept of course they don't make them so you can watch out for the box, box of wine is going down. So this is what happens. They go from, you know, a bottle--buying it in a bottle, they're buying it in a box, and then instead of waiting and until they're out, it goes on the weekly grocery list. So, you know, many -- maybe somebody in this room goes out shopping for mom or for grandma or for, you know, dad or whatever and that box of wine is on the shopping list. And so you think to yourself will, you know, that's not that much. Well, that's quite a bit, particularly if they're on a bunch of different medications also and--

Sherry Brown: Plus their age.

Kathy Wendt: Yeah.

Sherry Brown: Just they're age. If they're drinking a box a wine a week, that's a lot.

Kathy Wendt: Yeah. That's a lot.

Audience member: So I'm 70 years old and I drink a box of wine in a day, a week. My life can end tomorrow, so why should I not do it?

Sherry Brown: Well, that's the hundred thousand dollar question.

Audience member: [Inaudible Remark] I'm 75, so why should I not?

Kathy Wendt: I--I think of one of the things, if you ask people what they--Sherry said this the other day which I loved it. If they--what they--what their goals are? What do they want to be doing? A lot of people say, "I wanted to enjoy my grandchildren. I want to be able to play cards with friends and I want to be able to do those things." So you can kind of start there with, how is that going to interfere with what you want to do. I want to have a glass of wine with friends or whatever -- okay. That's different than sitting and drinking your box of wine every day.

Sherry Brown: However--

Kathy Wendt: We do have to--yeah, we do have to be respectful if that's the way want to do.

Sherry Brown: If that's works for them...My step dad, he's an alcoholic and he will drink until his last breath. That works for him. He has no plans on changing it because that works for him. There are no consequences he could see that really has a negative impact on him. He chooses to do that and that works for him. There's nothing that I or anybody else could do to change his mind because that works for him. When there's problems that arise in their lives, that's the angle that you would need to approach them with. Well, if you're falling down and you had stitches last week, and this week you broke your arm. Maybe you might want to look at how much you drink. Maybe you just had a couple of

more glasses of wine that day than you should of and approach it from there. Are you going to be okay on your own? Do you need to go into a home? You're falling down. I mean, but as long as it works for them, with any alcoholic and addict, you're not going to be able to help them as long as what they're doing is okay with them.

Seema Sehrawat: Yeah, it's across the board. It's no matter what age you are, not just older adult. If I can afford drinking and I have not hit that rock bottom, I'm going to continue. So that's what happens, you know, with every alcoholic or substance abuser. And we are not promoting and saying let them do it or it's okay. What we are saying is with older adults, aggressive treatments never work. So we can't be aggressive, we have to be respectful of their choices and their wishes and what they want to do. And the best approach is when you see any problem and you see bruises or when you see, you know, their health is declining or they have gone to the doctor and the liver is a big problem now -- that they are getting to that stage of liver cirrhosis and things like that. That could become the talking point.

Audience member: Yeah, that was what [inaudible]. And it was an intervention in a hospital setting that somebody actually talked with her, and she talked for the first time about some early traumas. And it wasn't a lot but it was enough for her to see that for what she did, the alternative was death or you're going to stop. And she's definitely--she's not--completely not drinking. But using the harm reduction piece, comparing what she was doing before she had the adversity. And she saw it and she's kind of like in reverse. But it's fascinating. But that one person, I'm just like gosh, what did they say? What was that moment to do what that social worker did...And there's a social worker and a nurse that came in at that moment she was hoping to that. And which makes me think as a professional that we never know. We ever know. I [inaudible] a long conversation, isn't it? I sent her some books and a few things that -- I don't even know if she read them. But it's like that little bit and, you know, it's interesting.

Kathy Wendt: Well it's because some of that, too, is because she's suffered the negative consequences. Its like, I don't know very many people that are happy when they're in hospital or that are happy about the idea of going a nursing home. So that's when you ask why. Because a lot of people will--my sister had a stroke last year. She has an alcohol addiction and she was--well, she almost died for one thing and she was miserable. Miserable being in a hospital, miserable, dealing with what was going on with her body and having people -- being helpless was a big thing for her. And that was one of the things I think that spurred her to, initially, not to go back to drinking was getting that kind of put on your face that this--this is what happens. And none of us want to be helpless, none of us want to be, you know--

Sherry Brown: Losing our independence.

Kathy Wendt: Yeah, losing our independence, none of us want to be in pain and have needles stuck in us and be -- none of us want that. And that's what's going to--it's not just you're going to drink. For most people, okay fine, you know, you're going to drink, you're going to drink until they drop dead. It doesn't happen that easily most of the time.

Sehrawat Seema: No.

Kathy Wendt: That it happens. I was looking out it, just a figure. In 1989, Medicare costs for alcohol-related hospitalizations--this is 1989, so I'm sure it's quadrupled -- \$233,543,500 dollars, just for alcohol related hospitalizations. So it's costing us a lot of money and it's costing them a lot of money.

Audience member: That's in 1989?

Kathy Wendt: That was in 1989.

Audience member: So it's probably, [inaudible].

Kathy Wendt: Yeah, that's what I'm saying – it's probably quadrupled by now. And I think that, of course, that's not going to mean anything to anybody that has an addiction. It's just that it's sometimes, it's that timing, and sometimes it's that hit in their bottom that they have to lose their driver's license or-

Sehrawat Seema: Their independence.

Kathy Wendt: Yeah, lose their independence.

Sherry Brown: That would be huge.

Audience member: Or could be their children. I mean there are people who really do -- they wouldn't be around you anymore. Maybe I think that's another piece of worry it makes that [inaudible].

Sherry Brown: Yes.

Kathy Wendt: Or how they're around you. That's another big issue. If they're--if they're around you, if you're surrounded. This happens to many families, is that children become enablers and codependent. And then you've got your kids...you know, you're laying in a hospital room with liver problems or maybe you've had a fall or something. This happens often: the adult kids come in and lecture them about "This is what happens." That's not the approach that we want to take either because that doesn't work.

Sherry Brown: Yeah, you've drank for a 40, 50, 60 years of your life -- somebody lecturing you, especially a family member, is not going to mean anything.

Sehrawat Seema: Or somebody coming and throwing all the bottles away. Or the alcohol, you know -- clearing your cabinet of all the meds or, you can throw it out once. The supply never ends. So that never works either, just throwing the bottle away.

Kathy Wendt: Questions? Did we exhaust that subject? [laughter].

Audience member: So could you talk a little bit about the kinds of assessment questions you might ask then, to older adults to get at [inaudible].

Kathy Wendt: I love that. Will you take that one Sherry?

Sherry Brown: Hmm.

Kathy Wendt: That if it works, if it's--if it's not working--

Sehrawat Seema: Then why? If it works for them, then they're not going to--they're not going to be there. What doesn't work about it? Why are they there? Usually it's a family referral, you know. Usually

the family absolutely is not willing to put up with one more minute of whatever. And so they'll seek treatment but....I don't know. I got lost.

Kathy Wendt: Well I was--I was thinking if you're asking --what questions you ask if you're family member, I think that's different as to what questions you ask as a professional.

Audience member: Right.

Kathy Wendt: You know, as a family member, we might be saying, if it's a mom or dad, or an uncle or aunt or whatever, it's...you start with, "How's your life? What makes you happy?" And you can kind of use one of the techniques I used is, "my friend. I have a friend who..." Because then if it's not about them, it's much easier to get them to talk about it. "I have a friend who--an older friend -- who drinks a box of wine once a week and, you know, I've gone over there and she's been passed out. I haven't been able to talk to her. I don't know whether to take her to the hospital or, you know, I don't know what kinds of things to suggest to her to do for fun. Grandma, what do you think?" Or, "Mom what do you think?" So they can talk about it in a third person kind of way and it's kind of a way to segue into what you want to talk about them. Or of course, talking about yourself, if you've had some issues with drug and alcohol yourself. And I know it's hard to talk to your parent about that--or aunt, uncle or whatever about that -- but I think that's another...Anything that makes it not about them and you kind of lead into them. And then it's also a time investment as a family member. Particularly with grief, and you probably come across this. When somebody losses their partner, for the first month everybody is there, everybody is there supporting them, bringing them casseroles, whatever. And then after a month, then nobody comes around. People don't know what to do with the grief, they don't know how to talk about the grief. They don't--they're uncomfortable, so friends quit coming around. Family gets busy doing other things. And so then that person starts to isolate. And then that box of wine becomes their best friend, or that pack of cigarettes and then...So part of the being a family member and wanting to be involved and wanting to help is to invest the time and the effort into it. You know, that--what it takes to be with that person and even if it's getting them to go to a meeting, taking them to an AA meeting or an NA meeting or whatever. Or doing something, just go in for drives, you know. I think a lot of people like to--even if you've been in Chico forever, maybe you haven't been to the Colusa Museum for a long time, or whatever. So, instilling hope. I think for me, that's one thing I see, is that people need to have hope. That's their one --they become hopeless and helpless, then it's really hard to get them to seek--if they don't have any hope, it's hard to get them to seek help.

Sherry Brown: What I also want to bring up is there's a lot of resources that I wasn't really aware of until I started looking. So there's a lot of resources out there to help the family, help them deal with the person, the older adult with the substance abuse problem. So there's a lot of resources out there and there are people that work in that community with older adults with substance abuse problems. And sometimes, the older adult may feel comfortable going in and have a one-on-one counseling by themselves, or maybe not, rather than in a group setting. It just depends what they prefer but there's a lot of options in our community which I really wasn't aware until I got into this and started researching. Which is wonderful, but most families don't know that. They just think, "Oh God I got to deal with this. I don't know how. And mom's not willing so I'll just call my brother and he can deal with it."

Audience member: Kathy, I want to ask you, do you use the [Inaudible Question] when they come in?

Kathy Wendt: Well, what we use at the outpatient treatment program at the County -- it's pretty much just a bio-psychosocial, like a mini-assessment. We really get more from kind of ongoing treatment than

we do from [inaudible]. Then I'm in private practice, you know, I do a full-on assessment. But I think there's so many questions that you just, you know, if--if we ask them in a particular style, the how to question thing. There's a lot of resistance to telling you the truth that--so I sort of, just my personal style, is to try to be humorous about it. Like one of the questions I'll ask is -- when I ask some question about alcohol and they say, "You know, I don't--I don't drink anymore." I say, "Well, do you drink any less?" Because they're not going to tell you that. Or, "You know, I used to use meth a long time ago but I haven't used it in a long time." Well, "What's a long time?" I haven't used meth since when, when was the last time? Because sometimes, a long time for somebody means last week and sometimes it means 6 years ago. So long time--I think, first of all, you have to build trust and you have to respect the person. And like you said if they're hanging onto that, they're going to do that until they die. "I'm 75, my life is done already." Well, 75 is young. You'll realize that as you get closer to it [laughs], how young that really is.

And I think as a family member particularly, we get scared because we don't want to -- we get scared and desperate and then we kind of just lose our focus and we get all kinds of, grabbing onto our family member trying not to let them go. And then, in our desperation, we forget to respect. We forget that self-determination piece. And we kind of have to circle around and then come at our family member from a different perspective of...And a lot of people my age or probably a little younger that will--they want their parent, they think their parent should come to counseling so I tell them, "We'll make it an appointment for yourself and ask your parent to come along." Because once they come in and build some trust, then they're more likely to come by themselves. But if you just say -- you get couples to come to counseling that same way -- don't ask your partner to go, ask your partner to come and be with you. Then they're not going to counseling, they're just coming to support you. They're still getting there one way or the other. And I have a lot--when we do orientation at the County, we do it every Thursday at 1 o'clock and a lot of times, younger people, say in their mid-20s or early 30s maybe, their parent brings--comes in with them and brings them in. And right away -- I hate to make a snap judgment right away, but I think, okay, so this person is being enabled because a parent is just going to work harder at their kid's recovery than the young person is. So I tried to get to that--that the person is going to be the client rather than a family member, and offer 1 or 2 family sessions. Do you want to talk about that because you really--that whole bringing the person with addiction out and treating them, and then putting them right back in the same system...

Sherry Brown: Yeah. We do offer a family group at Skyway House to help educate the family on--and it's not therapeutic. It's education only, on what some signs and symptoms or what to expect if someone's in recovery. Give the family a little bit of tools on dealing with the person that has a substance abuse problem. Because more times than not, the family doesn't have a clue what they're dealing with. They're caught in the wreckage of the addiction or the alcoholism but they really--they're just surviving. They don't know how to deal with it and what to look for. And there's been many families that have called me, scared to death because they knew that their child was taking drugs but they didn't know if they would die or not. They have no idea--they didn't know what to expect. And it is very scary. So definitely, educating the family and getting the family to participate regardless of the age difference... Regardless, because more times than not, the person with the substance abuse problem isn't the only one in the whole family that's ever had a substance abuse problem.

Seema Sehrawat: And--

Sherry Brown: They've seen it somewhere [laughs].

Sehrawat Seema: Yeah and, I want to say, in our society. But, you know, I stopped myself before saying "our society" because I also come from India and I have seen in treatment or how we function in the United States. The treatment approaches are--is very, very different. In India, the treatment is very family oriented, where you take the family along the treatment process, even help with them with their codependency issue. So that once the person goes back home or is reunited to the family, the family is also ready and prepared and they are not doing the enabling. Here, if you see the treatment, it's more individualistic. We treat the individual not the entire system or the family unit that the person belongs to. So when you are taking an individual, working with that individual and putting them right back in that system, the system hasn't changed. It's only that individual you were working with. So there are more chances to fall back and relapse because we don't have a huge, solid family support. And if not family, some friends who are there to support them along the way.

And you were--I think someone was asking this question about family and what we can do. Many times when you are working with your family members, don't you hit a roadblock? I don't know if you're good about talking with family about various issues. But my problem is, whenever I'm talking with my family about some things, I just hit that roadblock and I'm not able to communicate through them. And oftentimes, bringing a friend in or a family friend who's also a friend of my family, who knows how to deal with that or has awareness of that situation, and I can trust them about that issue - sometimes going that route also helps.

I have a friend, the friend I talked about earlier, too, who's in their 70s. And sometimes me talking to them really helps them because when I'm talking to them, they don't see it as I'm not being respectful of them as their child or I'm not thinking that they are capable of doing this or not. They see me more as a friend and that coming from a friend...rather than coming from their children, "Okay, you have to do this or that," you know.

So I think a family support, if you have support that works really well. In terms of assessment, you were asking what assessment questions, and I think Sue mentioned about the MAST-G. What that is, is the Michigan Alcoholism Screening Test and it has--it's a geriatric version. So it's especially made for older adults. In your practice, if you want to include that, it's a 24-question -- so it's kind of a little long. But that's a really neat little tool for you to assess somebody whether they have problem with alcohol or not. And when I'm mentioning this tool, I also want to mention TIP 32, which is Treatment Improvement Protocol by SAMSA. They have to block these tips for different age groups, and TIP 26 is specifically for working with older adults. And it's a great resource for you to have if you think you are going to work with older adults. It's free to download on the internet. If you just say TIP 26, I think it will come up. And it has tons of resources for you if you want to maybe read more about prescription drugs and prescription drug abuse and what can be done--

[Inaudible Question]

Sehrawat Seema: Treatment Improvement Protocol Number 26, it's called TIP 26. And it's like a 14-chapter document. It even touches on ethical issues, how you approach older adults --it's very comprehensive. It was developed in--I think I would say 1999. So it's little older -- it's 11, 12 years older - -but I think that the points they're taking about are still applicable. And Kathy and Sherry and I, we do reference to it a lot. We always go back and you can find all those assessment tools in there, too.

Another questionnaire that is really helpful and very short is the CAGE questionnaire. And I have handouts for you if you would like. It's only a 4-question questionnaire, very simple to start the

conversation, whether you're talking with the family member or as a professional, you are talking with somebody who's coming and wanting some help. The first question is, "Have you ever felt you should cut down on your drinking?" They must have had those moments where they might have thought, "You know, maybe I should think about how many glasses or how big of a glass I drink every day." For sure, that moment must have crossed them. Maybe they got a bruise, they fell, they got stitches or they had to go to the doctor because of some health complication. So that's a very good starting point, "Have you ever thought you should drink less?" So that starts that conversation. So this CAGE is -- "Have you ever felt guilty of how much you drink?" So this is like it really need 4-question questionnaire which can do that starting point for you. And we thought it would be a good resource for you to get. So if you need, I have copies for you. So that's in terms of assessment.

But when Kathy was talking about the physician and people were mentioning about physicians, one thing that was coming to my mind, do we even have a physician that specializes in geriatric medicine in town?

Audience member: There is a woman in town named [Inaudible] who has gerontology experience and does promote herself as having connections with older adults. [Inaudible]...But she only works part-time, so it may be difficult to get in to see her.

Sehrawat Seema: And in Butte County, we have more numbers of older adults in comparison to other County. So, you know, talk about a doctor who is specialized--only one doctor in our area who specializes in working with this particular population and is part time. And then amount of people and many of us won't even know that there are doctors that should be specialized in geriatric medicine to work with older adults. There is a special training for doctors. And these issues of not doing an ongoing assessment of their patients, just prescribing medicines because the patient is complaining of pain, not even asking questions is because our doctors are not trained and specialized. So what we need to do is doctor education or physician education, and maybe some awareness that they need to be more careful when they are working with older adults and that particular population because they take medicines and other--yes?

Audience member: I don't think it's necessarily that they're not trained. I think it's that, they don't have enough time. If the person's got MediCal, they don't care usually if they are older adult. And they just have to go there monthly to get their refills. So I mean, I'm sure--I know in nursing school, we did learn about geriatrics. I'm sure they do touch on that but it's just not a big thing for them.

Kathy Wendt: I think a lot of people, a lot of physicians have the attitude -- I remember a year ago we had a client that came in that had just been released from the hospital. And when he came in, I mean, he had to lean on the wall, he was so weak and malnourished and a long history of 45 years of drinking. And he'd gotten out of the hospital and the doctors had told him, "There's nothing we can do. You're, , basically, you're going to die." They told him that. He came in and he came to orientation and of course he was, you know, "I don't want to be in there with those drug addicts," kind of issues. And so I talked to him a little bit and just -- addiction is addiction. And I sort of asked him to be patient, told him I understood and asked him to be patient. He has over a year sober now. And as a matter of fact, he's sitting on the Behavioral Health Board, a consumer board member, which is awesome. So he was written off, basically, by the hospital staff. There wasn't any follow up with, "You could go here for treatment." He found us on his own, which was awesome. And just to see those -- there's a lot of stories that aren't successful; this one, this one is very cool but I think that a lot of—

We watched a video yesterday about a young man who had 244 arrests for drunk in public. And they just bring him in, book him, put him in a jail cell for overnight or 5 or 6 hours and turn him loose and book him again and turn him loose 244 times. And no one ever walked him to a treatment facility or did more than, "Here's a phone number." And it just takes more than, "Here's a phone number." Or sometimes -- we have one client that got clean and sober because drug and alcohol counselor tell him, "We can't do it." And that was his (the client's) way of saying, "Screw you." You never know what. It's so complicated; you never know what's going to work, you really don't.

Audience member: I kind of grapple with that we don't have specialist in gerontology. But, you know, if we have good family practitioner who has a good engagement skills and who really sees holistically -- I think we could build on that. And I think sometimes -- I was just reading recently, where if--what can a doctor say in terms of our weight? I mean, when a doctor says something to you, because I've just recently filled out a form...having had a colonoscopy. And they will ask you all the time when you go to the doctor. They don't think to ask you in person. That they'll ask you, "And how many times, what's your social drinking?" So I'm just thinking, do they look at that? Do they take that in? So I don't think it would take a lot but it is--but that I think that as we get older, I think we get discounted. And then--and then having somebody else with us there and all of those kinds of things. That power of a physician, you know. "I'm concerned, I've known you a long time, you know, how is this." You know, some of those questions. That could have an impact, I think.

Sherry Brown: I think it would help in some other ways.

Audience member: You know, I mean it was [inaudible] if my doctor would tell me I need to lose five pounds. It's very different than somebody else maybe telling me, I need to lose weight. I mean, they have that. But sometimes, I think they just see whatever the symptom is, whatever you're coming in for, and they're not relating it all. And that's frustrating.

Kathy Wendt: And it's the scariest place, it's always the last person to know. Every person, family and every person comes through our system that has an addiction to prescription pills -- the last person to know is the doctor.

Sherry Brown: Yeah.

Kathy Wendt: Like we will--we can go along and I might forget to ask that question, and they get into treatment and somebody gets clean and sober and so you go along and you think, "Okay, they're doing very well." And say they maybe even been my client for a couple of months and been in treatment. And they say something about going to doctors. I say, "Does your doctor know that you have an addiction to Soma or does your doctor know...?" "No. I don't want to tell her. I don't want to tell him." Really? Because it's that last -- it's like you don't want to give the name of your drug dealer. It's the last supplier you've got and they don't want it--it's that fear thing. They don't want to give up that last access, literally.

Audience member: Can you find the first line of defense? It's, like, caregivers. Especially with the economy like it is and more families are caring for their elders. And like awareness [inaudible]...It's a little off topic but I was wondering if you had this experience, like how often do you see caregiving substance abuse, and how do you deal with that?

Kathy Wendt: Report it. I had a friend that was in a really a nice, one of the really nice care homes, and she had ALS. And I remember asking, talking to the worker about how come she doesn't have a Phentonol patch, because she was on late stage. And the nursing home person said, "We don't give her those because the caregivers steal them." I was like, "So somebody who is dying can't get the medication that really would give them some relief because the people that you have employed here will steal it?" That--I mean -- and that's in a controlled environment. Let alone out there with in-home health workers and family members and...We see it all the time, of course you know. And then families get to use them all, they exchange pills like Sherry was saying. Her step dad gives her nieces and nephews--doesn't even think about it. "Oh you got a headache? Here's a Vicodin." You know, "Your back hurts, here's a Norco," and it doesn't even occur to them that you don't give your prescriptions away, that's illegal.

Audience member: It's a challenge when you have a person who is really elderly and dependent, and you don't know if their condition will get better or worse...

Kathy Wendt: I know, that's such a tough situation.

Audience member: Have you been involved in many treatments with a caregiver like in [inaudible]?

Sherry Brown: Well, when I first worked in the field, I had a client and his parents were elderly. And there were problems with the caregiver and we reported her. And he ended up going home to take care of his elderly parents, but all of their dishes were disappearing. And of course they were elderly, so they were probably collectibles. But other stuff stars disappearing. When he went home on a pass he... so we reported the person and got her out of there. Sometimes people don't want to say anything because that's the only person they have contact with, small price to pay.

Audience member: And if it's your child, [inaudible]. Just like the elder abuse.

Sherry Brown: Yeah.

Audience member: [Inaudible Remark]

Kathy Wendt: I was reading an article -- this is an interesting scenario. So you have an elder adult who has abused their children and then those same children are now responsible for their caregiving. Such a set-up for both, for both...

Audience member: That's why I do and feel at least it's possible. I need to know where it comes from...As I'm sitting here as a social worker, I've done home health work. Those folks, whether whoever the point of entry is, especially if they can't go out of the home unless there's a referral from a doctor or the other disciplines can... [Inaudible].

[Inaudible Discussion]

Kathy Wendt: I can't think of any other—We just want them to be educated about it so they can be a better caregiver.

Audience member: Are we talking a formal caregiver or the informal type of caring. I mean like a--

Kathy Wendt: A family member.

Sherry Brown: Yeah.

Audience member: It sounds like you do have a group, though, a group for family members that are interested in...

Sherry Brown: Yes, anybody that would be interested in gaining some tools can call Skyway House and we have a family group there. So it could be--it doesn't have to be the family. It could be a friend of someone, it could be a caregiver. I would--that's a great hope, that all the caregivers will step up and get educated and become the best caregivers. I mean, we will pray for that.

Kathy Wendt: That's our dream world. Yeah it'd be nice if they had an agency that did -- to become a caregiver, to be an in-home health worker, you had to go to this wonderful training that we could run. Yeah, that would be great.

Audience member: Well, well at the county, we've trained our IHSS providers. They talked about substance abuse and overdose in their trainings, then they have to go to [inaudible]...That was an hour and a half [laughs]

[Inaudible Discussion]

Sehrawat Seema: Just an orientation.

Audience member: It's a PowerPoint [laughter] basically.

Sehrawat Seema: It's an orientation.

Audience member: A problem is that in Glenn County home health care workers get \$8.50 an hour. There's only so much you can ask of a person for \$8.50 an hour. Inaudible Remark]

Audience member: What does it tell you?

Audience member: It's different.

[Inaudible Question]

Sherry Brown: I'm the director of the outpatient services. In outpatient we have the older adult group, we have regular outpatient, we have services for teens.

[Inaudible Discussion]

Sehrawat Seema: And I think the flyer and Sherry's contact information is here, so if you want to grab that I think that would be a good resource.