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Older Adults and Substance Abuse: A Program Evaluation

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Older Adults and Substance Abuse: A Program Evaluation

by

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May, 2013

MSW Clinical Research Paper

Presented to the Faculty of the
School of Social Work

St. Catherine University and the University of St. Thomas
St. Paul, Minnesota

In Partial fulfillment of the Requirements for the Degree of

Master of Social Work

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The Clinical Research Project is a graduation requirement for MSW students at St. Catherine University/University of St. Thomas School of Social Work in St. Paul, Minnesota and is conducted within a nine-month time frame to demonstrate facility with basic social research methods. Students must independently conceptualize a research problem, formulate a research design that is approved by a research committee and the university Institutional Review Board, implement the project, and publicly present the findings of the study. This project is neither a Master's thesis nor a dissertation.

Abstract

In the year 2011, the first wave of the baby boom generation reached age 65, the age of retirement. Over the next 18 years the U. S. Administration on Aging (2010) reports that these boomers will turn 65 years old at the rate of approximately 8,000 per day. Substance abuse among this cohort has been called an invisible and silent epidemic. Many social service agencies will have to deal with the negative and complicating factors which substance abuse causes. Alcohol and substance misuse among the elderly is associated with many negative consequences, including functional impairment, increase risk of dementia, raised mortality and higher utilization of healthcare services. In addition, it is estimated that 4.4 million adults age 50 and older will be substance dependent and in need of treatment by the year 2020. The focus of this clinical research project was to evaluate the Senior Recovery Program and how effective the program is at meeting its goals through the eyes of its participants. The researcher measured former clients overall satisfaction with the Senior Recovery Program by assessing their perceptions of sobriety maintenance, age appropriate program design, relationship with family, social skills and support and overall program satisfaction. Findings of this program evaluation indicated the Senior Recovery Program is effective in delivering quality chemical health recovery services to older adults through the focus of five areas of service. This program evaluation will add to the research collection and improve understanding and needs of older adults who require substance abuse treatment.

Acknowledgements

I would like to thank Felicia Sy, PhD, my committee chair, for her commitment and dedication to this program. My committee members Gwen Lutz, MSW and Carol Zierman, MS whom were invaluable in their dedication and insights through this project. I would also like to extend a special thank you to the Senior Recovery Program Staff for making my project possible and for taking the time to share your knowledge and expertise.

I would also like to thank my family members as well as my nine year old nephew who sat many nights at the kitchen table as this project evolved. Also a warm and loving thank you to my cohort members which I have developed lifelong friendships, you guys rock! Finally, I would like to thank my fiancé for the patience and understanding he showed through this lengthy process.

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Older Adults and Substance Abuse: A Program Evaluation

Elderly, make up the largest growing segment of the population in the United States. Over the next 18 years the U.S. Administration on Aging (2010) reports that the baby boom cohort, defined as those born between 1946 and 1964, will turn 65 years old at the rate of approximately 8,000 persons per day. By the year 2030, this population will make up approximately 19% of the total population (U.S. Census Bureau, 2000). As the size of the older adult population grows, so will the substance abuse issues among this cohort, which has been called an invisible and silent epidemic (Ferrell & Sorocco, 2006).

This invisible epidemic is very problematic and poses an important public health concern for older adults. Substance abuse in older adults may result in psychiatric disorders, physical disabilities and societal problems for the abuser and the general public (Briggs et. al., 2011). It has been documented that older substance abusers have disproportionately higher rates of medical mortality, hospital and nursing home admissions, and emergency room visits all which are alcohol-related (Blow et. al., 2000; Briggs et. al., 2011; Rigler, 2000). Furthermore, the U.S. Department of Health and Human Services (DHHS, 1998) noted the abuse of alcohol and prescription drugs among older adults is one of the fastest increasing health concerns in the United States. Additionally the DHHS estimated that 2.5 million older adults have problems related to alcohol, and that more than one-fifth of those, age 60 and over, whom are hospitalized have a diagnosis of alcoholism. Congressional reports from the Select Committee on Aging indicated that in 1990 the estimated costs of health care for patients age 60 and over with a diagnosis of alcohol issues, were estimated to be \$60 billion (HR Report No. 102-852, 1992; Schonfeld & Dupree, 1995). It has been estimated that by the year 2020 approximately 5 million older adults will need treatment for substance abuse problems (Gfroerer et al., 2003).

The previous estimates paint a startling image of the growing volume of older adults who will need social services in the near future. There is a significant need for mental health professionals to be informed and aware as they prepare to meet this population's treatment needs. Social workers constitute the largest group of mental health providers trained to take an environmental perspective towards clients, which provides an advantage when compared to other professionals (U.S. Department of Health and Human Services, 2000). Older adult substance abuse is a serious matter, which has been widely ignored and has far-reaching consequences for older adults, their families and associates, and tax payers. Social workers are the gatekeepers in most human service agencies; they are the frontline defense to help those in need.

The focus of this clinical research project is to evaluate the Senior Recovery Program and how effective the program is at meeting its goals through the eyes of its participants. This evaluation is important when approaching the topic of elderly substance abuse because of the dearth of information, especially in social work literature regarding this important matter. The following literature review and findings are offered in hope that the information presented serves to benefit future practice and research efforts with regard to older adults with substance abuse issues. Additionally, the findings will contribute to the foundation of information and potentially spur interest by others to continue to expand the knowledge base on this topic.

The following literature review will address the prevalence of substance use and abuse in older adults in the United States. A review of the two distinct groups, early-onset and late-onset, substance abusers will be presented. Under-diagnosis and misdiagnosis of elderly substance abusers is explored as well as the role of diagnostic and ageism issues. Lastly, themes of denial of substance use and abuse and age specific substance abuse treatment programs are reviewed.

Prevalence of Substance Use and Abuse in Older Adults

Much confusion and variance has been presented in research literature as to the actual prevalence of substance use and abuse among older individuals. Studies of the prevalence of substance abuse in older adults vary from 1 to 22 percent. The discrepancies in prevalence estimates among studies are due to diagnostic criteria and tools used by researchers, some employ much more conservative estimates compared with those that use more liberal definitions. Prevalence varies due to populations which are studied (clinical or hospital populations vs. general population), study's location (urban vs. rural), how alcohol-related problems are defined (self-report vs. specific diagnostic criteria) and age parameters used (Hanson & Gutheil, 2004; Mahoney, 2007; Menninger, 2002).

Gfroerer et al. (2003) postulated that as the baby boom cohort ages there would be a substantial increase in the number of older adults with substance abuse problems due to the aforementioned variables. Additionally, the baby boomer population has much higher rates of substance abuse than any previous cohort. The authors applied a regression model to predict problematic substance abuse among the older adult population. The data support a projected future substance abuse prevalence increasing from 2.5 million in 1999 to 5.0 million by the year 2020. This study also indicates that there is a lack of supportive services to address these anticipated needs. Other research support the need for increased social services, as well as, improved tools for measuring substance abuse among older adults (Blow et al., 2000, Briggs et al., 2011).

Of the 5065 elderly primary care patients surveyed by Adams (1996), 15 percent of males and 12 percent of females drank in excess of limits recommended by the National Institute of Alcohol Abuse and Alcoholism (>7 drinks per week for women and >14 drinks per week for

men). Noted in the study was the high percentage of aged individuals diagnosed with active alcoholism, between 4 percent and 10 percent of those age 60 and older. These numbers presented by this study is consistent with most prevalence estimates presented in current literature.

Older adults are also uniquely vulnerable to the effects of alcohol because of their high risk for drug or alcohol interactions, because older adults generally take more prescription and over-the-counter medications than do younger individuals. Prevalence estimates for older adults seeking treatment in hospitals, primary care clinics, and nursing homes report much higher rates of concurrent use of alcohol with prescription and over the counter drugs. Onudus et al (1999), noted that on a daily basis older adults consume more over the counter drugs than any other age group, in addition older adults currently make-up 12.4 percent of the population and consume 25 to 30 percent of all prescription drugs.

Early-Onset and Late-Onset of Substance Abuse in Older Adults

Older adults with substance abuse issues are generally identified in two distinct groups; those defined as early-onset substance abusers and late-onset substance abusers. Early-onset abusers make up approximately two-thirds of elderly substance abusers. Individuals identified as early-onset abusers are those who are identified as abusing alcohol or drugs before the age of 50 and have long-standing substance related problems. Early-onset abusers frequently have an extensive history of physical and mental health problems; as well as antisocial behaviors, socioeconomic, and familial declines all directly associated with their substance abuse history (Benshoff, Harrawood & Koch, 2003; Memmott, 2003; Rigler, 2000). Hanson and Gutheil (2004) note that early-onset problem drinkers use alcohol as a maladaptive coping response to difficulties experienced in life. Early-onset substance abusers are usually more identifiable

because of prior treatment contact and earlier problematic behaviors which were identified by others. When these early-onset problem drinkers begin to experience difficulties during the aging process, there is a continuation of life-long patterns of alcohol abuse and dependence in reaction to these difficulties.

The descriptor, late-onset substance abuser, which make up one-third to half of older adult substance abusers, refers to those whose substance use and related problems began usually after the age of 50 (Benshoff, Harrawood & Koch, 2003; Dufour & Fuller, 1995; Hanson & Gutheil, 2004; Memmott, 2003; Rigler, 2000). Most literature indicates that late-onset substance abuse is usually precipitated by one or more specific life changing events such as loss of a spouse, divorce, retirement, and/or health changes associated with the aging process. Atkins (1996) and Menninger (2002) noted that later-onset substance abusers have been seen as more related to situational factors such as significant losses, death of a spouse or close friends, economic decline, unfulfilled expectations and new or worsening medical problems. These are all risk factors which contribute to late-onset substance abuse by older adults.

Many of the late-onset abusers turn to alcohol to alleviate the emotional, psychological and physical pain and stress of the aging process. A study by Onen et. al. (2005), indicated among elderly drinkers, the problems related to the social environment were the contributing factors of their late-onset substance abuse. The most frequently observed problems with their social environments were problems with their primary support groups, and housing. Other identified problems were related to loss, grief and isolation; mainly death of wife, husband or a child, absence of communication with relatives, living alone, or adjustment to life-cycle transition such as retirement and institutionalization. Gurnack (1997) noted several social risk factors which contributed to late-onset substance abuse. Social risk factors included inadequate

social support, isolation due to disability or loss of role due to retirement, or separation from family and friends from death or geographical moves. Most literature also indicates both economic and social status influence substance abuse in older adults as well as in other age groups. Atkins (1996) found that lower income older adults tend to drink less than more affluent individuals. Additionally late-onset substance abusers are more educated and higher incomes than early-onset substance abusers.

Under or Misdiagnosis of Substance Abuse

There are numerous reasons why older adults are underdiagnosed or misdiagnosed for substance abuse. Diagnosis of this problem is crucial for preventing potential severe consequences. Some of the deficiencies are the result of limited information concerning diagnosis, prevention and treatment strategies for older adults. Generally younger adult's substance abuse issues become evident by problems on the job or with a spousal relationship, drunken driving incidents and acute medical disorders related to drinking or drugs. Older adult's experience fewer psychosocial consequences because many are retired, live alone and no longer driving (Memmott, 2003; Myers, Dice & Dew, 2000). With fewer psychosocial consequences many older adults continue their substance abuse which leads to physical consequences. Many older individuals go to their primary physicians with symptoms which are caused by their substance misuse but mimic changes of aging and are not detected by their doctors. Physicians are well positioned to diagnose substance abuse problems in the elderly yet there are significant shortcomings in their recognition of this issue.

The pathology of substance abuse in older adults is further obscured by concurrent medical conditions and medications. The use of both alcohol and drugs can cause behaviors and mood changes that mimic the effects of these medical and psychological problems (Dufour &

Fuller, 1995; Menninger, 2002). Many of the illnesses which present atypically or nonspecifically; such as anemia, altered cognition, and liver abnormalities are often missed as indicators of substance abuse problems since these illnesses appear more frequently in patients who are older.

Benshoff, Harrawood & Koch (2003) as well as Rinfrette (2009) point to several possible reasons why healthcare providers are not diagnosing this abuse in more of their patients. Underdiagnoses may be attributed to shortened patient-physician consultation times due to changing healthcare system protocols. Physicians focus their attention on physical symptoms, rather than mental health symptoms, which can mimic age-related illnesses such as confusion, memory loss, and loss of coordination. Likewise, many health care providers attribute behaviors related to drinking to the natural aging process rather than alcohol abuse. Physicians are often untrained in gerontology and pharmacokinetics as it relates to the older person and substance abuse.

Additionally, physicians may be influenced by stereotypical attitudes which might include pessimistic beliefs about treatment efficacy or that only lower-socioeconomic individuals are substance abusers. Ferrell and Sorocco (2006) noted that physicians were much less likely to screen for substance abuse in older adults, women, educated individuals and those of a higher socioeconomic status. Furthermore, avoidance of the topic of alcohol and substance abuse was attributed to the practitioner and patient feeling uncomfortable discussing the topic.

Diagnostic Issues

Older adults present unique challenges when attempting to diagnosing substance abuse and dependence among the population. One common benchmark used to diagnose alcohol misuse is the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV;

American Psychiatric Association, 2000), Alcohol Abuse/ Dependence criteria. There are several diagnostic limitations when using this tool with regard to older adults and substance abuse/ dependence. The DSM-IV criteria for substance dependence is defined by an individual's: tolerance, withdrawal, period of use, desire to cut down or control, time spent in obtaining or recovering from effects, social and recreational activities reduced or given up, and physical or psychological problems which are likely to have been caused or exacerbated by the substance use. Substance abuse is defined by failure to fulfill work, school or home obligations; use of substance during hazardous situations, legal problems contributed to use of substance and continued use despite social or interpersonal problems which were exacerbated or caused by use of a substance.

Many of the criteria put forth by the DSM-IV are irrelevant in relation to where older individuals are in their biological life cycle. The criteria fails to address the biological changes, which occur during the aging process in relation to an individual's tolerance to alcohol. The body changes biologically as humans age, lean body mass diminishes and the total volume of body water decreases. Ethanol is a water soluble compound which upon consumption is distributed throughout the total body. Since the volume of body water is much less in older adults than younger adults the same amount of alcohol dose produces a much higher concentration in older adults than younger adults (Dufour & Fuller, 1995; Oslin, 2006).

Biological vulnerability and variance in social dynamics of the aging make it difficult to produce valid and generalizable estimates of prevalence for substance abuse or dependence among older adults (Blow, Oslin & Barry, 2002). Older adults need much less alcohol to become inebriated. In addition, older adults tend to be retired and have less social or

occupational obligations, thus their substance use will not interfere with those activities as they do with younger adults (Atkins, 1996; Martin & Widlitz, 2002).

The National Institute on Alcohol Abuse and Alcoholism (NIAAA, 1995) have recommended that older men ([greater than or equal to] 65 years) consume no more than one standard drink per day with a maximum of two drinks on any one occasion, or seven drinks on average per week. The standards for older women are stricter--less than one drink per day and a maximum of four drinks per week. Further, consumption in a single session of five or more drinks for men and four or more for women constitutes another component of risky drinking. Recent population-based research has found that exceeding drinking guidelines is associated with increased risk of alcohol-use disorders, with particularly high risk among individuals exceeding daily consumption guidelines of five or more drinks for men and four or more drinks for women (Blow et al.), leading to calls for the inclusion of quantity and frequency measures as a component of diagnosis of alcohol disorders (Li et al., 2007). Research specific to older adults has questioned the wisdom of concise consumption guidelines. One criticism is that confounding variables such as health status and psychiatric/medical comorbidity make estimates of healthy and unsafe levels of drinking invalid for many older adults.

Ageism

Ageism contributes to the problem of recognizing substance abuse issues in older adults since many people apply different quality-of-life standards to older adults than younger adults. Some beliefs remain that older people do not become substance abusers, or they should be left alone to do what they please since they have limited time left to live (Hanson & Gutheil, 2004; Renfrette, 2009). Family and friends often feel they are taking away one of the last things that their older loved one enjoys. Ironically, drinking in older age is not enjoyment but aloneness

which leads to isolation, depression and loss of enjoyment (Zimberg, 1996). Additionally, caregivers many times believe that older adults cannot become alcoholic and if they do, they cannot be helped. Families hold a view that treatment will be unsuccessful in making major changes in the lives of older people. This assumption that treatment cannot help elderly people is an ageist attitude which causes families and caregivers to deny and minimize the existence of substance abuse problems (Perkins & Tice, 1999).

According to Thornton's (2002) study on ageist stereotypes there are six ageist beliefs or myths which are held by many in our society about older adults. The general beliefs include that older adults are ill, sickly, or disabled, lack mental acuity or are senile, suffer from depression and are crabby, are not sexual, are all boring and homogenous. The last two of the six ageist beliefs are very detrimental when addressing the needs of older adults with substance abuse issues. These include the general ageist beliefs that older adults: lack vivacity; loss their vigor and ultimately decline. Finally and possibly the most damaging to older adults with substance abuse issues is the myth of an inability to learn or change. These myths are built primarily on half-truths, false knowledge, and stated as ageist stereotypes about that which is known.

Thornton (2002) further argues that these myths perpetuate false images of being old and stereotype aging individuals. The study indicates that these myths unintentionally work to displace older people from their communities into situations where they are undervalued, unproductive, less capable and dependent on systems. In addition these stereotypes demean and marginalize the lives of aging adults especially in regard to those who have substance abuse issues. This may be due to the belief by family members and physicians that older adults will not or cannot change their behaviors related to substance use.

Denial

With any age group there is a resistance to accepting a flaw in one's person, this is denial of a problem. Not only does the substance abuser deny that they have a problem but their friends and family also deny the existence. Menninger, 2002 and Rigler, 2000, note that even when a referral to treatment programs are made many patients decline because of perceived negative stigma related to substance abuse. The baby-boom cohort (those born between 1946 to 1964) for whom predominant cohort values suggest that alcoholism is a moral weakness or character defect. Older adults rationalize their problems as age-related problems not alcohol related, which are causing their confusion, balance issue and other symptoms.

Ferrell and Sorocco (2006) and Van Wormer (1995) both identified shame and denial as a barrier to assessment and diagnosis of alcohol problems among older adults. They noted that many families consider an alcohol problem to be a private matter, preventing family members from seeking help. Furthermore, family members add to the denial and downplay issues associated with substance abuse.

Van Wormer further postulates that denial is one of the basic human defense mechanisms which allow individuals to function when reality is too difficult for the mind to handle. Three basic components of denial include minimization, rationalization and projection. Rationalization is used by the families of older adult substance abusers by their ageist thinking. The families rationalize the over use of alcohol by believing that older adults are in their twilight years and they deserve to drink if they choose to (Hanson & Gutheil, 2004; Renfrette, 2009). Minimization is often seen with older adults because they have more sedentary lifestyles and they do not suffer the social consequences compared to younger substance abusers (Martin & Widlitz, 2002). Lastly, projection is the placing of blame elsewhere other than the individual.

This is not as common with older substance abusers than with younger, this is due to older adults feeling more shame and guilt associated with their substance abuse issues (Van Wormer, 1995).

Age Specific Treatment Needs

Very little literature exists in regard to age specific treatment devoted to older adults. A large dearth in literature is due to the complexity of this social problem. Substance abuse treatment for older adults is complicated by underdiagnoses or misdiagnoses as well as intentional disregard or intentionally ignoring the problem by healthcare providers and the families of older adult substance abusers (Myers, Dice & Dew, 2000). Menninger (2000) noted that older substance abusing adults present fewer social warnings; they have fewer occupational difficulties, legal problems and suicide attempts. If signs of substance abuse are apparent many older individuals are in denial and are reluctant to seek treatment because of shame and embarrassment.

Reaction to this public health issue has come from a federal level with the legislative authorities established the Substance Abuse and Mental Health Services Administration (SAMHSA) within the U.S. Department of Health and Human Services (DHHS). Responsibility was placed on SAMHSA's Center for Substance Abuse Treatment (CSAT) to promote and evaluate substance abuse services for older Americans and provide a summary of what is known about substance abuse among older adults (CSAT, 1998). CSAT (1998) put forth a publication which represents the consensus of an expert panel on the best practices for identifying and treating substance abuse problems in older people: Treatment Improvement Protocol (TIP) # 26 on "Substance Abuse Among Older Adults".

The common consensus among researchers is that while treatment methods are generally the same for substance abusers of any age, special attention should be given to the unique and

distinctive needs of older substance abusers, e.g. coping with stressful life events, overcoming social isolation, and attention to grief and loss. Dufour and Fuller (1995), Myers, Dice & Dew (2000) and TIP (1995), offered several recommendations for treatment of older adults: (1) age-specific emphasized group treatment with supportive approaches, avoiding confrontation and shaming; (2) a focus on coping with depression, loss and isolation; (3) emphasis on rebuilding social support network (4) develop a pace and content of treatment appropriate for the older adult; (5) employing staff members who are interested and experienced in working with older adults; (6) develop linkages with aging services, community programs and medical services for referral and case management needs. In addition to the recommendations listed above an emphasis on an age specific setting has been suggested. This is beneficial in creating a culture of safety and respect, emphasizing a holistic approach to treatment with the flexibility to adapting treatment protocols in response to client needs (Myers, Dice & Dew, 2000).

Even though very few studies have been conducted regarding age specific treatment programs, the existing research have shown that older adults are more compliant and have outcomes as good as, or better than, those of younger alcoholics (Dufour & Fuller, 1995; Myers, Dice & Dew, 2000; Oslin, 1996). Additionally, these authors found that aging adults should be in treatment with other aging adults rather than mixed ages. Atkinson, 1995 noted that completion rates for older adult specific treatment programs are modestly better than for mixed age specific treatment groups.

Satre et al. (2004) noted several positive results for older adults in their study of alcohol and drug treatment outcomes of older adults versus middle-aged and younger adults. The findings indicated that older adults had 52 percent of reported abstinence from alcohol and drugs in the previous 30 days versus 40 percent of younger adults. Furthermore, this study found that

after a five year follow-up of individuals who participated in a managed care program which integrated medical and behavioral health treatment, indicated abstinence rates of older adults were higher than those of younger adults.

A summary of the literature reveals valuable information for the advancement of elderly substance abuse recognition and treatment. However little research has been conducted regarding what the significant issues are when approaching elderly substance abuse and what interventions work best with this specific cohort. This research project was developed to explore if the Senior Recovery Program is delivering a quality product of substance abuse treatment based on the opinions of former clients who have completed the treatment program. The findings from this evaluation will add to the research collection regarding older adults and chemical health treatment programs and inform the program of its relative strengths and weaknesses. The program evaluation is guided by the use of Continuity Theory as described by Atchley (1999) as a means of exploring substance abuse in older adults, which is further discussed below.

Conceptual Framework

Continuity Theory presents an approach, which helps to explain how people adapt over their lifetime to changes. Older adults make adaptive choices to maintain and preserve existing external and internal structures (Atchley, 1999). This is accomplished by applying familiar strategies in familiar arenas of life. When older adults are presented with change associated with normal aging they draw upon their past experience to maintain their continuity as an adaptive strategy to accomplish aging objectives. Atchley (1999) noted that continuity exists as adults develop and adapt, continuously learning from their past experiences over their life span.

Individuals do not really change as they age, but rather they become more of what they have always been.

Exploration of the four dimensions/frameworks of an individual are required when applying the continuity theory to positive aging. These four dimensions/frameworks include idea patterns (internal patterns), lifestyle patterns (external patterns), personal goals, and adaptive capacity. When applying this theory to older adults all four dimensions/frameworks must be maintained and remain consistent overtime for positive aging to be obtained. However all four dimensions/frameworks are interdependent upon each-other at times.

Internal Patterns Framework

Internal patterns are the ideas, mental skills and information which are organized into loose constructs such as personal goals, beliefs, values, moral structure, temperament and coping strategies. When life choices and adaptation to change is required older adults are motivated to maintain the inner mental constructs which have been obtained by consistent discriminating investments. It has been noted that psychological security is obtained by consistency of these internal patterns. The self-schema is literally made-up of hundreds of self- referent ideas, Atchley (1999) has organized the self into self-concept (objective concepts of self), ideal self (hope for self), self-values (personal goals), and self-evaluation (moral self-assessment). It is believed that individuals are not passive participants but rather active in the formation, development and perpetuation of the self. These self-schemas allow a person to, promote and defend the self as well as form motivation and developmental direction.

External Patterns Framework

External patterns are the social roles, relationships, activities, geographic locations and living environments are dimensions/frameworks which individuals have formed through patterns

organized in their minds. By setting these patterns and making selective decisions individuals produce the greatest satisfaction for themselves which are possible in each given situation. They continue to concentrate their energy towards continuity of environments and activities. With continuity of activities and relationships social support is preserved and this leads to maintaining solid concepts of self and lifestyle. Continuity in these areas also leads to psychic payoffs; since external continuity usually involves avoidance of devalued self-schemas and the actualization of ideal self.

Developmental Goals Framework

The third dimension/framework which the Continuity Theory assumes is adults have goals for their developmental direction. Personal goals by older adults include, obtaining spiritual growth as well as maintaining and improving family relationships. Many of these goals are affected by life experience; older adults apply life experience when making decisions about what aspect to focus their attention on, what activities they will engage in, which groups to join and what communities to live in. These decisions are based on the premise that whatever choice meets the most positive development possible.

Adaptive Capacity Framework

The last dimension/framework which is assumed by the Continuity Theory is the adaptive capacity of older adults to adjust to changing circumstances. The process of adaptation is how individuals adjust to fit a situation or environment. Many of us adapt to change almost automatically without even an awareness that adaptation occurred. Each person has a level of capacity for routine adaptation; at times changes may surpass the capacity and require unusual, non-routine steps to deal with them. Coping is an attempt to overcome difficulty; coping skills and mechanisms are developed throughout a lifetime to grapple with significant, overwhelming

changes in circumstances. Generally people use consistent coping strategies throughout their adulthood.

Two ways are used by aging individuals to adapt; the first is a gradual and routine and second is by activating or mobilizing coping skills and resources to deal with crisis. Aging is in some ways a slow moving process, but adults can change, but these changes are gradual and are accommodated routinely. However, when a crisis occurs conscious coping and social resources are required by older adults. Atchley (1999) postulates by middle adulthood most individuals know what their adaptive strengths and weaknesses tend to be. When continuity is maintained in an adults basic coping resources, such as adequate income, good health, high physical functioning and adequate social support, then adaptation is made much easier. If these basic resources are maintained properly, reaction to change or loss of one resource can be compensated by those that remain intact. However, if an individual does not maintain continuity in basic resources they will have much greater difficulty adapting to change and loss.

Continuity vs. Discontinuity

Continuity is the process of adapting to change; continuity can be a motivator for people to plan in advance for changes by applying proactive coping measures. Proactive coping measures include anticipating change, preventing and neutralizing problems. This is done by taking conscious steps in preventing chronic illness and disabilities and planning sufficiently for future needs. Ways which individuals engage in proactive coping would be to exercise daily, and engage in retirement planning to ensure financial needs are met in retirement years.

Reactive coping requires individuals to identify and activate coping skills and resources to adapt to sudden difficult changes. Reactive coping resources include external factors such as

social support systems, aid from family and friends. Internal coping skills include positive religious beliefs, and maintaining an optimistic attitude.

Discontinuity is experienced when persons experience substantial and disruptive negative changes which are beyond their coping capacity. Individuals who have not maintained their continuity are unable to mobilize coping resources and skills which lead to long-term discontinuity of viewpoint and/or lifestyle. Poor adaptive skills and coping mechanisms lead to negative coping mechanisms, such as alcohol which leads to further discontinuity. When aging adults use alcohol to cope with change they destroy their proactive coping measures by lack of leading a healthy lifestyle, reactive coping skills, and by isolation.

The Continuity Theory assumes evolution, not homeostasis, allowing for change to be integrated into a person's history without causing disturbance or instability. A parsimonious explanation is offered by the writer as to how the continuity theory explains and describes the ways individuals use concepts of their past to negotiate their futures and structure their choices in response to changes generated by the aging process.

Continuity theory is extremely important when exploring older adults and how they adapt to change and cope with substance abuse issues. Older adults may lose their continuity because of age related change or losses; they then become susceptible to substance abuse because of their discontinuity. The Senior Recovery Program, which is an age specific substance abuse treatment program described in the following section, brings older adults back to a place of continuity by providing structure and goals which are focused on returning to a balance of sobriety and positive living. It is suggested that programs that address continuity will produce high ratios of client satisfaction and successful treatment outcomes. The Senior Recovery

Program through their mission, goals and objectives produces high ratios of client satisfaction and successful treatment outcomes.

Program Description

The Senior Recovery Program is a nonprofit organization whose mission is to provide affordable treatment and continued support for adults, 50 years of age or older, suffering from addiction so they may regain happy, productive lives. As the longest-running alcohol and chemical dependency program specifically for seniors in the nation (founded in 1972), the Senior Recovery Program incorporates two successful concepts into one program. First, by focusing exclusively on seniors, the program provides a more targeted, welcoming, and ultimately successful environment for seniors than they may have experienced or would experience at more multi-aged program. Secondly, the Senior Recovery Program offers comprehensive services under one umbrella: both a clinical treatment outpatient program and a supportive services program, the Seniors Providing Elder Care (S.P.E.C.) program. This wrap-around service model was established in July 2008 through a grant from the Minnesota Department of Human Services, Chemical Support Division.

The current program uses the wrap-around model of clinical and support services, from this point forward we will be referring to this as the Senior Recovery Program, but will include both program aspects. The Senior Recovery Program continues to serve adults age 50 or more, who are dependent on alcohol, prescription medication, or illegal drugs within a 15 mile radius of St. Paul, Minnesota. While the Senior Recovery Program has served older adults in recovery for more than 35 years, the need for senior specific services is both growing within the overall senior population as well as increased alcohol, prescription drug, and street drug abuse among this age group. The Senior Recovery Program model is grounded in the theory that older adults

are more successful in recovery and sobriety maintenance when they are supported by same-age peers and have access to resources to help with their age-specific barriers to success, such as social isolation and lack of reliable transportation. One large factor in Senior Recovery Program success is its co-location with the Senior Recovery Center's clinical, age-specific treatment program, which facilitates clients' sense of belonging and purpose in their recovery journey.

To achieve its overall goal of enhancing seniors' recovery from alcohol and drug abuse as a process of change including improved health, wellness and quality of life, the Senior Recovery Program focuses its activities and resources on multiple objectives (as cited in program pamphlet, 2012):

- Provide regularly scheduled social activities for seniors.
- Provide transportation for senior's participation in the Senior Recovery Program.
- Obtain and maintain a program vehicle for providing rides.
- Provide community outreach about Senior Recovery Program to seniors, family members, and healthcare and other professionals serving seniors. Identify and engage older adults with alcohol and substance abuse problems through outreach activities.
- Provide case management services to all Senior Recovery Program participants.
- Provide continued care assistance to seniors who have completed the Senior Recovery Program.
- Provide group-based socialization activities designed to overcome the barrier of isolation faced by many older adults.
- Streamline staff and organizational structure in order to serve more clients at lower cost than previous funding.
- Strengthen partnerships with community resources, volunteers and Senior Recovery Center's co-located clinical treatment program in order to better facilitate a smooth holistic experience for clients.

Client specific outcomes identified for the Senior Recovery Program, short-term (within five months of participation) include:

- Improved sobriety
- Increased opportunities for positive social interactions
- Improved familial relationships
- Improved social skills and support
- Overall program satisfaction

Long-term (within six to 12 months of participation) include:

- Continued sobriety six months after completing the program
- Compliance with medical treatment plans and medications
- Continued health improvement(s)
- Increased independent living skills
- Improved relationships with their family
- Reduced isolation and increased socialization
- Increased overall quality of life

Method

Research Design

The purpose of this program evaluation was to determine if the Senior Recovery Program provided satisfaction to its clients through the delivery of age-specific services, which promote recovery and sobriety maintenance with a holistic experience for its clients. A client survey, developed by ACET Inc., was used by the researcher to measure former clients overall satisfaction with the Senior Recovery Program by assessing their perceptions of sobriety maintenance, age appropriate program design, relationship with family, social skills and support and overall program satisfaction.

Sample

The samples for this research project were older adults who had previously participated in the Senior Recovery Program in St. Paul, Minnesota. Former clients were randomly selected, and surveys, letters of consent, and envelopes were provided to the Programs Director for distribution during a winter 2013 social event held at the Senior Recovery Program Center. Approximately 55 former client's received surveys.

Protection of Participants

Several measures were put in place in order to ensure the protection of human subjects and minimize the potential risks associated with this study. Informed consent was sought from

each participant through an informed consent form, which was approved by the University of St. Thomas IRB prior to the data collection process (see Appendix B.). The consent form outlined the nature of this study, confidentiality, potential risks and benefits to the participant, the procedures used and contact information. A copy of the consent form was given to each participant for his or her records.

All identifying data for each participant was kept strictly confidential so that it would not be possible to identify the participants in any manner. All completed surveys were sealed in unmarked envelopes and collected by the Senior Recovery Program Director. The Program Director returned the survey's to the researcher via U.S. mail. After the data was received by the researcher, all data items were kept in a secure, locked file cabinet at the researcher's residence. No others had access to the file cabinet. All data entered into computer data bank was password protected. All data and collected surveys will be shredded, and or destroyed on June 1, 2013.

Data Collected

A client survey, developed by ACET Inc., was used by the researcher to measure former clients overall satisfaction with the Senior Recovery Program. The survey consisted of 15 Likert scale questions, two qualitative questions, and four demographic questions (see Appendix C). Participants will rate the Likert scale questions from 1 to 4 (1 = Strongly Agree, 4 = Strongly Disagree). Each question is designed to fall into one of five areas used for assessing the Senior Recovery Program at meeting its goals through the eyes of its participants. The five areas which clients rated their perceptions included: sobriety status and maintenance, age appropriate program design, family relations, social skills and support, and overall program satisfaction. Demographic questions addressed the participants' gender (male or female), race or ethnicity

(African American or Black, Latino or Hispanic, American Indian, White, Asian or Pacific Islander and Other), Age grouping (50-55, 56-65, 66 and older), and Living status (Live Alone or Live with Others).

The two qualitative questions were used to promote personal perspectives about the Senior Recovery Program. These questions: *‘What do you like best about the Senior Recovery Program?’*, and *‘What would you like to see improved or changed about the Senior Recovery Program?’*, were utilized for further analysis and insight to program effectiveness and satisfaction. It was also used to develop recommendations for further improvement of the Senior Recovery Program.

Analyzed Data

A review of returned surveys was analyzed using descriptive statistics. The statistics which were utilized in this program evaluation included frequency distributions, both simple and grouped frequency distributions. Additionally, measures of central tendency were utilized to describe the mean age of survey respondents. Pie charts were used to visualize the findings extracted from the data. Tables 1-6. summarize Demographic Descriptive Data which will include participants gender (male or female), race or ethnicity (African American or Black, Latino or Hispanic, American Indian, White, Asian or Pacific Islander and Other), Age grouping (50-55, 56-65, 66 and older), and Living status (Live Alone or Live with Others). Tables 6-10 and Figures 1-5., indicated responses to the five areas which clients rated their perceptions, these included: sobriety status and maintenance, age appropriate program design, family relations, social skills and support, and overall program satisfaction. Tables 11. and 12. Indicated respondents written answers to survey questions 18. and 19. respectively.

Findings

The current study evaluated the Senior Recovery Program to determine if it provided satisfaction to its clients through the delivery of age-specific services which promote recovery and sobriety maintenance with a holistic experience for its clients. A client survey, developed by ACET Inc., was used by the researcher to measure seniors overall satisfaction with the Senior Recovery Program by assessing their perceptions of their sobriety maintenance, age appropriate program design, relationship with family, social skills and support and overall program satisfaction. A detailed description of the participants in the study is followed by the statistical analysis of the data gathered from the participant responses of the Senior Recovery Program survey instrument.

Descriptive Data

This section includes basic demographic information about the 27 survey respondents. Included in the following tables are gender, race, living status, marital status, income and age of all respondents.

Table 1.

Gender

	Frequency	Percent	Valid Percent	Cumulative Percent
Men 1	17	63.0	63.0	63.0
Women 2	10	37.0	37.0	100.0
Total	27	100.0	100.0	

This nominal variable measures the respondents’ gender. The response options are male or female. The findings of this study in Table 1 show that 17 respondents (63.0%) are male, 10 respondents (37.0%) are female. These findings show that the large majority of the sample is male.

Table 2.

Race

	Frequency	Percent	Valid Percent	Cumulative Percent
African American	2	7.4	7.4	7.4
Latino or Hispanic	2	7.4	7.4	14.8
White or Caucasian	23	85.2	85.2	100.0
Total	27	100.0	100.0	

This nominal variable measures the respondents’ race. The response options are 1=African American, 2= American Indian, 3= Asian or Pacific Islander, 4= Latino or Hispanic, 5= White or Caucasian, 6= Other. The findings of this study in Table 2 show that 2 respondents (7.4%) are African American, 2 respondents (7.4%) are Latino or Hispanic, 23 respondents (85.2%) are White or Caucasian and 0 respondents are American Indian, Asian or Pacific Islander or Other. These findings show that the large majority of the sample is White or Caucasian.

Table 3.

Living Status

	Frequency	Percent	Valid Percent	Cumulative Percent
Live Alone	14	51.9	51.9	51.9
Live with Others	13	48.1	48.1	100.0
Total	27	100.0	100.0	

This nominal variable measures the respondents’ living status. The response options are live alone and live with others. The research question for the study is: How many respondents’ live alone and how many respondents’ live with others in the sample? The findings of this study in Table 3 indicate that 14 respondents (51.9%) live alone, 13 respondents (48.1%) live with others.

These findings show that the variable living status is nearly evenly split between the two variables.

Table 4.

Marital Status

	Frequency	Percent	Valid Percent	Cumulative Percent
Single	7	25.9	25.9	25.9
Married	6	22.2	22.2	48.1
Divorced	9	33.3	33.3	81.5
Separated	1	3.7	3.7	85.2
Widow or Widower	4	14.8	14.8	100.0
Total	27	100.0	100.0	

This nominal variable measures the respondents' Marital Status. The response options are 1= Single, 2= Married, 3= Divorced, 4= Separated and 5= Widowed or Widower. The findings of this study in Table 4 show that 7 respondents (25.9%) are single, 6 respondents (22.2%) are married, 9 respondents (25.9%) are divorced, 1 respondents (3.7%) are separated and 4 respondents (14.8%) are widowed or widowers. These findings show that the largest marital status categories of respondents are divorced.

Table 5.

Income Per Year

	Frequency	Percent	Valid Percent	Cumulative Percent
Under 15,000	16	59.3	66.7	66.7
15,000 to 20,000	2	7.4	8.3	75.0
20,000 to 30,000	2	7.4	8.3	83.3
30,000 to 40,000	2	7.4	8.3	91.7
70,000 or Higher	2	7.4	8.3	100.0
Total	24	88.9	100.0	
Missing System	3	11.1		
Total	27	100.0		

This nominal variable measures the respondents' income. The response options are 1= under 15,000, 2= 15,000 to 20,000, 3= 20,000 to 30,000, 4= 30,000 to 40,000, 5= 40,000 to 50,000, 6= 50,000 to 60,000, 7= 60,000 to 70,000 and 8= more than 70,000. The research question for the study is: What are the yearly income levels of the people in the sample? The findings of this study in Table 5 show that 16 respondents (53.9%) yearly income is less than 15,000, 2 respondents (7.4%) income are 15,000 to 20,000, 2 respondents (7.4%) income are 20,000 to 30,000, 2 respondents (7.4%) income are 30,000 to 40,000, 2 respondents (7.4%) income are 70,000 or higher, no respondents have income of 40,000 to 50,000, 50,000 to 60,000, or 60,000 to 70,000. These findings show that the large majority of the respondents have income of less than 15,000 per year.

Table 6. Age of Respondents

Age of Respondents

	N	Minimum	Maximum	Mean	Std. Deviation	Skewness	
	Statistic	Statistic	Statistic	Statistic	Statistic	Statistic	Std. Error
Age	27	50	86	62.00	8.417	.835	.448
Valid N	27						

The ratio variable, Age or Respondent, measures respondents’ ages included in the sample. The possible response options ranged from 0 to undefined. The research question for the study is: What is the mean age or respondents in this sample? Table 6 shows that, of the 27 respondents, the mean age was 62 years. The minimum response was 50 years and the maximum response was 86 years.

In addition to data collected regarding demographic characteristics, data was similarly collected by determining the sum of items (questions) to produce a scale score. The total of five dataset scale scores were produced from the data collected from the Senior Recovery Program survey.

The first descriptive variable is respondents’ attitudes regarding their abilities to maintain their sobriety due to their participation in the Senior Recovery Program. This is operationally defined as “Sobriety Maintenance” Scale Score. The responses were collected using a Likert-scale on each individual item from 1 (Strongly Agree) to 4 (Strongly Disagree); the Scale Score was the sum of items 1, 2 and 3 of Senior Recovery Program survey. The three items used to indicate the variable sobriety maintenance included: 1.) Since being involved in the Senior Program, my alcohol/drug usage has? 2.) The Senior Program has given me the tools to help me maintain my sobriety. 3.) I believe I can maintain my sobriety.

The possible range of scores was between 3 and 12; 12 indicated the highest score and 3 indicated the lowest score. As indicated below 26 respondents received a scale score of their responses in relation to their sobriety maintenance. There were zero responses which scored 7-12, which indicated all 26 respondents who answered items 1, 2 and 3, either Strongly Agreed or Agreed with the statements indicating their abilities to maintain their sobriety were due to their participation in the Senior Recovery Program.

A higher score indicated a strong disagreement of the abilities to maintain sobriety due to the participation in the Senior Recovery Program. No respondent indicated a scale score of 7-12, for the category sobriety maintenance. A lower scale score indicates a strong agreement of the abilities to maintain sobriety due to the participation in the Senior Recovery Program. All 26 respondents indicated lower scale scores between 3-6.

A recoding of variables was applied to combine variables into two categories due to the responses of survey participants. Responses were re-coded into 1.0 Strongly Agree and 2.0 Agree. No respondents indicated any answer of 3.0 Disagree or 4.0 Strongly Disagree to any of the items used to create the Sobriety Maintenance Scale Score, two categories were eliminated, 3.0 Disagree and 4.0 Strongly Disagree.

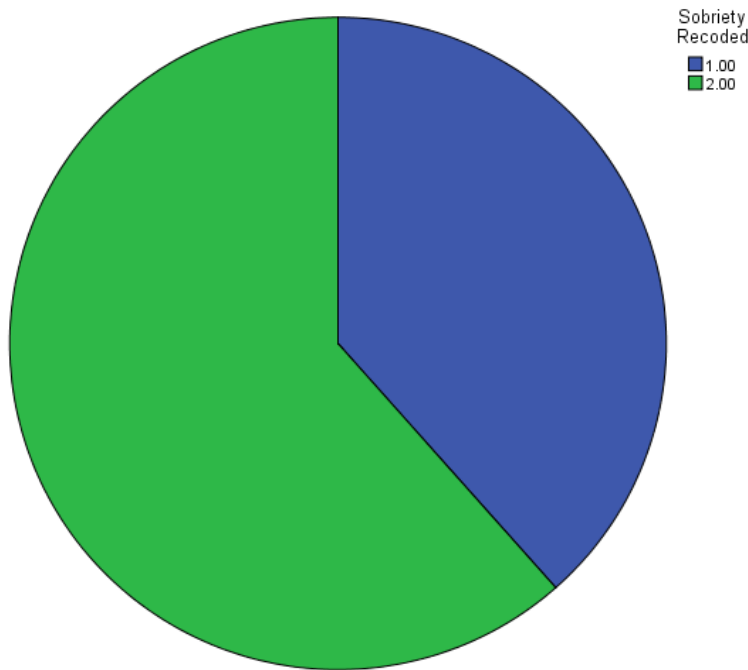
The research question sought to be tested by this statistical procedure was: what is the distribution of scores in this sample who believe that the Senior Recovery Program has helped with their personal abilities to maintain sobriety? This descriptive variable was measured for percentage of agreement and disagreement displayed in Table 6. and Figure 1.

Table 6. Sobriety Maintenance

Sobriety Maintenance

		Frequency	Percent	Valid Percent	Cumulative Percent
Strongly Agree	1.00	10	37.0	38.5	38.5
Agree	2.00	16	59.3	61.5	100.0
Disagree	0.00	0.0	0.0	0.0	
Strongly Disagree	0.00	0.0	0.0	0.0	
	Total	26	96.3	100.0	
Missing	System	1	3.7		
Total		27	100.0		

Figure 1. Sobriety Maintenance



The second descriptive variable is respondents’ attitudes regarding the age appropriate program design, with a focus of building and maintaining peer support through their participation in the Senior Recovery Program. This is operationally defined as “Age Appropriate Program”

Scale Score. The responses were collected using a Likert-scale on each individual item from 1 (Strongly Agree) to 4 (Strongly Disagree); the Scale Score was the sum of items 4, 5, 6 and 7 of Senior Recovery Program survey. The following four items were used to produce the Age Appropriate Program Scale Score: 4.) I have maintained positive support Networks with my peer. 5.) It is important to me to socialize with others on a regular basis. 6.) Staff encourages me to spend time socializing with others. 7.) The Senior Program has helped me achieve a healthy lifestyle.

The possible range of scores was between 4 and 16; 16 indicated the highest score and 4 indicated the lowest score. A recoding of variables was applied to combine variables into three categories due to the responses of survey participants. As indicated below 26 respondents received a scale score regarding their responses in relation to opinions of the age appropriate program. There was one respondent which indicated a scale scored between 9-16, which indicated all 25 respondents who answered the sum of items 4, 5, 6 and 7 which indicated their attitudes about the age appropriate program either Strongly Agreed or Agreed with the statements indicating the age appropriate program helped build and maintain peer support.

One respondent indicated a scale score of 9-16, for the variable, age appropriate program. This indicated only one respondent held the opinion, they were unable to build and maintain peer support by participating in age appropriate program offered by the Senior Recovery Program. A higher score indicates a strong disagreement of the abilities to build and maintain peer support through participation in the Senior Recovery Program. A lower score indicates a strong agreement of the abilities to build and maintain peer support due to the participation in the Senior Recovery Program. A recoding of variables was applied to combine variables into three categories due to the responses of survey participants. Responses were re-coded into 1.0

Strongly Agree, 2.0 Agree, and 3.0 Disagree. No respondents indicated any of Strongly Disagree to any of the items used to create the Age Appropriate Program Scale Score, this category (4.0 Strongly Disagree) was eliminated.

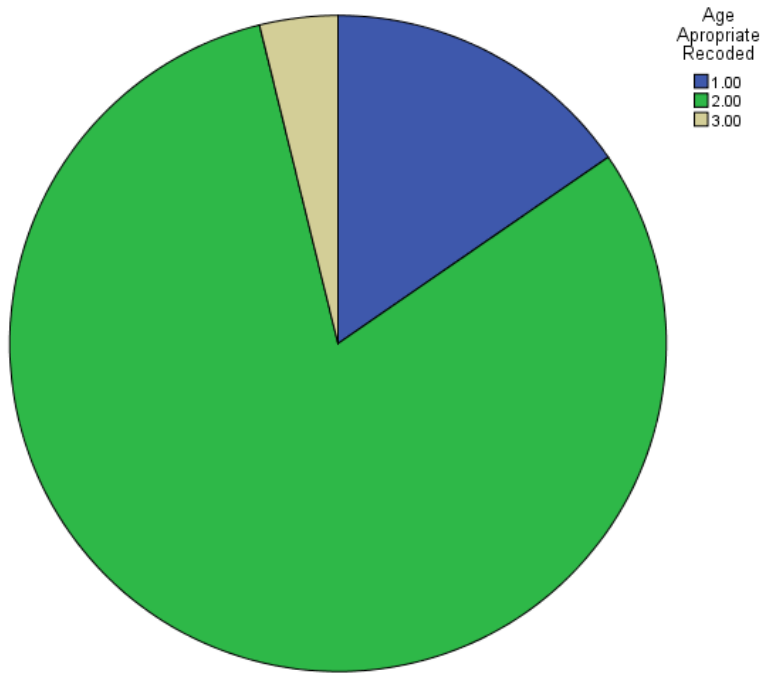
The research question sought to be tested by this statistical procedure was: what is the distribution of scores in this sample who believe that the Senior Recovery Program has helped with their personal abilities to build and maintain peer support? This descriptive variable was measured for percentage of agreement and disagreement displayed in the Table 7. and Figure 2.

Table 7. Age Appropriate Program

Age Appropriate Recoded

		Frequency	Percent	Valid Percent	Cumulative Percent
Strongly Agree	1.00	4	14.8	15.4	15.4
Agree	2.00	21	77.8	80.8	96.2
Disagree	3.00	1	3.7	3.8	100.0
	Total	26	96.3	100.0	
Missing	System	1	3.7		
Total		27	100.0		

Figure 2. Age Appropriate Program



The third descriptive variable is respondents’ attitudes regarding their abilities to improve family relations due to their participation in the Senior Recovery Program. This is operationally defined as “Family Relations” Scale Score. The responses were collected using a Likert-scale on each individual item from 1 (Strongly Agree) to 4 (Strongly Disagree); the Scale Score was the sum of items 8, 9 and 10 of Senior Recovery Program survey. The three items used to indicate the variable family relations included: 8.) It is important to me to have a positive relationship with my family. 9.) Staff have helped me communicate more openly with my family. 10.) My family supports my sobriety.

The possible range of scores was between 3 and 12; 12 indicated the highest score and 3 indicated the lowest score. As indicated below 26 respondents received a scale score regarding their responses in relation to their sobriety maintenance. There were zero responses which scored 7-12, which indicated all 26 respondents who answered the sum of items 8, 9 and 10,

which indicated their attitudes about family relations either Strongly Agreed or Agreed with the statements indicating improved family relations.

No respondent indicated a scale score of 7-12, for the category family relations. A higher score indicates a strong disagreement of the abilities to improve family relations due to the participation in the Senior Recovery Program. A lower score indicates a strong agreement of the abilities to improve family relations due to the participation in the Senior Recovery Program.

A recoding of variables was applied to combine variables into two categories due to the responses of survey participants. Responses were re-coded into 1.0 Strongly Agree and 2.0 Agree. No respondents indicated any answer of 3.0 Disagree or 4.0 Strongly Disagree to any of the items used to create the Family Relations Scale Score, two categories were eliminated, 3.0 Disagree and 4.0 Strongly Disagree.

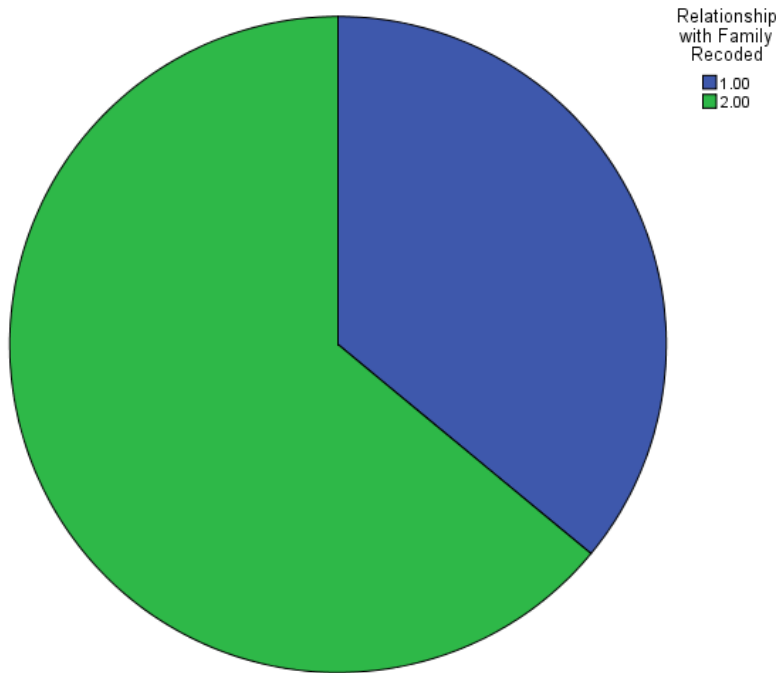
The research question sought to be tested by this statistical procedure was: what is the distribution of scores in this sample who believe that the Senior Recovery Program has helped with their personal abilities to improve family relations? This descriptive variable was measured for percentage of agreement and disagreement displayed in Table 8. and Figure 3.

Table 8. Relationship with Family

Relationship with Family

		Frequency	Percent	Valid Percent	Cumulative Percent
Strongly Agree	1.00	9	33.3	36.0	36.0
Agree	2.00	16	59.3	64.0	100.0
	Total	25	92.6	100.0	
Missing	System	2	7.4		
Total		27	100.0		

Figure 3. Relationship with Family



The fourth descriptive variable is respondents' attitudes regarding their abilities to negotiate social skills and receipt of support due to their participation in the Senior Recovery Program. This is operationally defined as "Social Skills and Support" Scale Score. The responses were collected using a Likert-scale on each individual item from 1 (Strongly Agree) to 4 (Strongly Disagree); the Scale Score was the sum of items 11, 12, 13, 14, 15 and 16 of Senior Recovery Program survey. The six items used to indicate the variable social skills and support included: 11.) Senior Program staff helped me achieve a better quality of life. 12.) I ask for help when needed. 13.) I was given sufficient individual attention from staff. 14.) Senior Program staff seemed to understand my situation. 15.) I felt strongly supported by staff. 16.) Senior Program staff care about me.

The possible range of scores was between 6 and 24; 24 indicated the highest score and 6 indicated the lowest score. As indicated below 26 respondents received a scale score regarding

their responses to their social skills and support. There were zero respondents indicated a scale score between 13-24. All 26 respondents indicated scale scores between 6-12 which denote all respondents Strongly Agreed or Agreed with the items that operationally define Social Skills and Support Scale Score.

No respondent indicated a scale score of 7-12, for the category social skills and support. A higher score indicates a strong disagreement of the abilities to negotiate social skills and receive support due to the participation in the Senior Recovery Program. A lower score indicates a strong agreement of the abilities to negotiate social skills and receive support due to the participation in the Senior Recovery Program.

A recoding of variables was applied to combine variables into two categories due to the responses of survey participants. Responses were re-coded into 1.0 Strongly Agree and 2.0 Agree. No respondents indicated any answer of 3.0 Disagree or 4.0 Strongly Disagree to any of the items used to create the Family Relations Scale Score, two categories were eliminated, 3.0 Disagree and 4.0 Strongly Disagree.

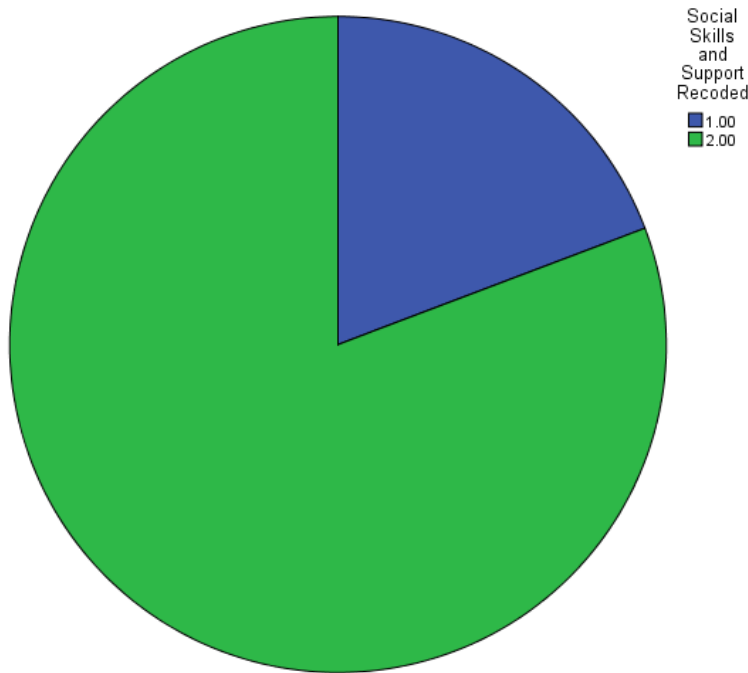
The research question sought to be tested by this statistical procedure was: what is the distribution of scores in this sample who believe that the Senior Recovery Program has helped with their personal abilities to negotiate social skills and receive support? This descriptive variable was measured for percentage of agreement and disagreement displayed in Table 9. and Figure 4.

Table 9. Social Skills and Support

Social Skills and Support

		Frequency	Percent	Valid Percent	Cumulative Percent
Strongly Agree	1.00	5	18.5	19.2	19.2
Agree	2.00	21	77.8	80.8	100.0
	Total	26	96.3	100.0	
Missing	System	1	3.7		
Total		27	100.0		

Figure 4. Social Skills and Support



The fifth descriptive variable is respondents’ attitudes regarding their satisfaction of services due to their participation in the Senior Recovery Program. This is operationally defined as “Satisfaction of Services” Score. The responses were collected using a Likert-scale on each individual item from 1 (Strongly Agree) to 4 (Strongly Disagree); the Score was the analysis of one item included in the Senior Recovery Program survey. The item used to indicate the variable

satisfaction of services included item: 17.) I am satisfied with the level of services offered by the Senior Program.

The possible range of scores was between 1 and 4; 4 indicated the highest score and 1 indicated the lowest score. As indicated below 27 respondents received a scale score regarding their responses to their satisfaction of services provided by the Senior Recovery Program. There were zero respondents indicated a scale score between 3-4. All 27 respondents indicated scale scores between 1-2 which denote all respondents Strongly Agreed or Agreed with the items that operationally define Social Skills and Support Scale Score.

No respondent indicated a score of 3-4, for the category satisfaction of services. A higher score indicates a strong disagreement of the satisfaction of services due to the participation in the Senior Recovery Program. A lower score indicates a strong agreement of the satisfaction of services due to the participation in the Senior Recovery Program.

A recoding of variables was applied to combine variables into two categories due to the responses of survey participants. Responses were re-coded into 1.0 Strongly Agree and 2.0 Agree. No respondents indicated any answer of 3.0 Disagree or 4.0 Strongly Disagree to any of the items used to create the Family Relations Scale Score, two categories were eliminated, 3.0 Disagree and 4.0 Strongly Disagree.

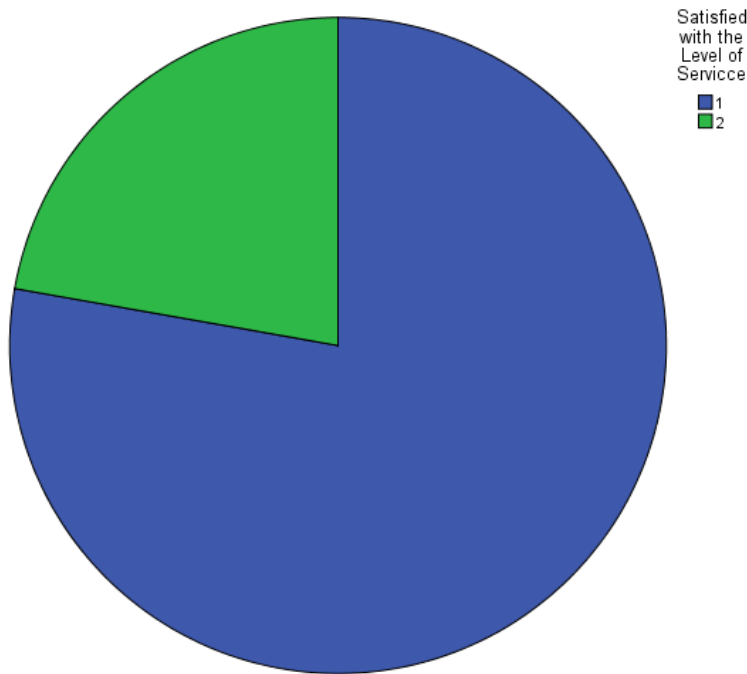
The research question sought to be tested by this statistical procedure was: what is the distribution of scores in this sample who are satisfied with services provided during participation of the Senior Recover Program? This descriptive variable was measured for percentage of agreement and disagreement displayed in Table 10. and Figure 5.

Table 10. Satisfaction of Services

Satisfied with the Level of Service

		Frequency	Percent	Valid Percent	Cumulative Percent
Strongly Agree	1	21	77.8	77.8	77.8
Agree	2	6	22.2	22.2	100.0
	Total	27	100.0	100.0	

Figure 5. Satisfaction of Services



In an attempt to wean valuable information the researcher included two open-ended questions which respondents wrote in their answers. Included below are the 24 respondent answers to the item 18 included in the survey and ** respondent answers to item 19 of the survey. The two questions were included in the survey as item numbers 18 and 19: 18.) What do you like best about the Senior Recovery Program? 19.) What would you like to see improved or changed about the Senior Recovery Program? Due to the small amount sample size all responses are listed below in Table 11. and Table 12.

Table 11. Responses to item 18.

<p>18. What do you Like best about the Senior Recovery Program?</p> <ul style="list-style-type: none"> • The welcome feel/caring; the people – staff/clients • Help repair my self-confidence and self-esteem; being able to talk without being judged; fellowship, crafts, groups. • Friendly communication. • Friendly people and groups. • They pick you up for groups and meetings; they listen to you. • I like it all! • The people. • The people. • Being in recovery with people my own age; friendships, the interns and my counselor Jim. • All or it. • Fellowship, honesty. • Being with people my own age. • The caring, Pete and Jim. • The groups. • Relationship with the Senior Recovery People. • Talking with others. • Relationship with people my age, morning program, staff support and other people support. Relate to people with the same problems and life styles. • The caring, the understanding, the serenity, good insights from staff and clients – I like the guest speakers - they have all been good! • Openness, honesty, help, caring, attention to the individual, people getting rides to treatment; My counselor, all together good feeling. • The friendly and honest people. • Being able to relate to individuals who are in similar situations. • Everybody about the same age. • The understanding of “all” the people here. • I feel true love here at Senior Recovery from the staff, volunteers, and my peers.
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The Table 12. below indicates the responses to item 19. The item was stated as follows: 19.)

What would you like to see improved or changed about the Senior Recovery Program? All respondent answers are included in the table.

Table 12. Responses to item 19.

<p>19. What would you like to see improved or changed about the Senior Recovery Program?</p>
<ul style="list-style-type: none"> • More on Mental Health topics, more speakers, and discussions. • I would like to have a counselor here. • Nothing. • Weekend AA or something. • I wish it could be longer in hours. • Help me more. • We need more closeness. • You guys do a good job. Any social event is great. • Have one on one before it time to go home. • The cabinet room needs to be improved!! • Everything covers my needs pretty much. • More social activities. • I don't have any suggestions - I really like this place. • Nothing. • Little. • I am still learning. • It's good! • More topics that stimulates thinking outside of the box.

Discussion

At the start of this research there were several areas which were explored to indicate whether clients that participated in the Senior Recovery Program received and were happy with the services provided by the program. The indicators of program success and satisfaction were categorized into the following: sobriety status and maintenance, age appropriate program design, family relations, social skills and support, and overall program satisfaction.

Additionally the guiding framework Continuity Theory as described by Atchley (1999), explored four dimensions/frameworks of an individual to explain how people adapt over their lifetime to change. The findings of this program evaluation point to the positive activation of the four dimensions/frameworks of survey respondents.

When adults age all four dimensions/frameworks must be maintained and remain consistent overtime for positive continuity in aging to be achieved. The four dimensions/frameworks include Internal Patterns Framework (personal goals, beliefs, values and coping structures), External Patterns Framework (social roles, relationships, activities living environments), Developmental Goals Framework (obtaining spiritual growth and maintaining and improving family relationships) and Adaptive Capacity Framework (capacity of older adults to adjust to changing circumstances).

Continuity is achieved in aging when positive, proactive coping measures and adaptive skills are maintained. Older adults experience discontinuity when they experience substantial and disruptive negative changes which are beyond their coping capacity. Poor adaptive skills and the use of negative coping mechanisms lead to discontinuity. The use of alcohol and drugs is a negative coping mechanism which leads to further discontinuity and further destroys their proactive coping measures.

The findings of this program evaluation point to the positive activation of the four dimensions/frameworks of an individual as described by Atchley (1999). In the following sections each category which was created to evaluate program satisfaction will also present findings on how the findings support the conceptual framework when exploring substance abuse in older adults.

Sobriety maintenance

In an attempt to evaluate whether or not the Senior Recovery Program provided support for sobriety maintenance clients answered a series of questions relating to their alcohol and/drug usage, tools they obtained to help maintain sobriety and the belief in their own abilities to maintain sobriety. All clients who completed the Client Evaluation Survey reported being successful in decreasing or ceasing substance use and abuse. All clients reported either strongly agreed or agreed the Senior Recovery program gave them the necessary tools to maintain sobriety and believed in their own ability to maintain sobriety. This is indicated in Table 6. and Figure 1. This is evidenced in the total of 27 respondent's strong agreement and agreement the Senior Recovery program gave them the necessary tools to maintain sobriety and believed in their own ability to maintain sobriety.

Atchley (1999) postulates that most individuals as they age activate and utilize basic coping resources, such as, good health, high physical functioning and adequate social support. When older individuals develop substance abuse issues they are not adequately using or activating their coping skills. When they are under the influence they are unable to make proper decisions or utilize their coping resources, this leads to discontinuity. According to the findings of this program evaluation respondents indicated they either completely stopped using alcohol/drugs and or decreased their use. This leads them to return to the utilization of healthy

coping mechanisms rather than using poor coping mechanisms as alcohol or drugs. The respondents indicated the coping skills/tools to maintain sobriety were provided by their participation in the Senior Recovery Program.

Age Appropriate Program Design

Even though very few studies have been conducted regarding age specific treatment programs, the existing research have shown that older adults are more compliant and have outcomes as good as, or better than, those of younger alcoholics (Dufour & Fuller, 1995; Myers, Dice & Dew, 2000; Oslin, 1996). Additionally, these authors found that aging adults should be in treatment with other aging adults rather than mixed ages. Participant responses indicate the Senior Recovery Program age specific program design was helpful to aid in their recovery. Support for this was indicated by self-reported responses to question 18 in the Client Survey. The question stated: "What do you like best about the Senior Recovery Program A total of 19 responses specifically stated their penchant to be around individuals within their age groups. The following responses were stated; *"The people are friendly," "peers," "groups," "Being in recovery with people my own age," "people my age", and "Everybody about the same age"*.

Additionally, Atchley (1999) noted that when the External Patterns Framework, which are formed by an individual's making selective decisions and conforming to their established patterns which govern their individual social roles, relationships, activities and living environments are disrupted by substance abuse issues these individuals are not selecting the best decisions to produce the greatest satisfaction in a given situation. This is yet another area which becomes disrupted through the use of drugs and alcohol the individual becomes deregulated. Participants of this current study indicated that age specific programming allowed for open discussion with individuals their own age and similar situations. Additional statements to

survey question 18. support this view: *“Talking with others,” “Relationship with people my age,” and “Being able to relate to individuals who are in similar situations.”*

Family Relations

As noted by prior research many older adults have under diagnosed chemical health abuse and misuse. Older adult’s experience fewer psychosocial consequences because many are retired, live alone and no longer driving (Memmott, 2003; Myers, Dice & Dew, 2000). With fewer psychosocial consequences many older adults continue their substance abuse which leads to physical consequences. Older adults tend to isolate and let their familial bonds laps. As indicated by current research findings all respondents strongly agreed or agreed with the Senior Recovery Programs ability to help them communicate and establish a positive relationship with their families.

Hanson & Gutheil, 2004; and Renfrette, 2009, noted in their studies that families felt that older adults should be left alone to do what they please since they have limited time left to live. In addition, the above authors declared that families and caregivers often feel like they are taking away the last things their older loved one enjoys. However, the average age of the 27 survey respondents who participated in this program evaluation was 62 years old. Age 62 years old was well below the Average Life Expectancy of age 75.9 for white males and age 80.8 for white females reported by the U.S. National Center for Health Statistics, National Vital Statistics Reports in 2010. This indicates that many of the clients involved in substance recovery still have years to live and enjoy life to the fullest.

Social Skills and Support

The findings of this study indicate satisfaction based on client perceptions of the Senior Recovery Program in regard to social skills and support are again supported by high levels of

agreement with program satisfaction. As presented in the literature review Menninger, 2002 and Rigler, 2000, noted many older individuals decline treatment programming because of perceived negative stigma related to substance abuse treatment. However, findings in the Senior Recovery Program evaluation highlighted the joy and relief which seniors felt as a result of communicating with others their own age and with similar situations.

Support for this was indicated by self-reported responses to question 18 in the Client Survey. The question stated: “What do you like best about the Senior Recovery Program?” Over 10 responses specifically stated their liking and partiality of the fellowship and communication. The following responses were stated: *“Help repair my self-confidence and self-esteem; being able to talk without being judged; fellowship.”* *“Friendly communication.”* *“Staff support and other people support.”*

Exemplary Model

The overall findings of this study indicate that the Senior Recovery Program is an exemplary model of a recovery program. What make this program so great are several factors that go beyond the scope of this study. Several indicators that this study identified as producing success among the participants included five categories: sobriety status and maintenance, age appropriate program design, family relations, social skills and support, and overall program satisfaction, discussed in earlier sections. What is working for this program seems to be the combination of the five factors discussed as well as several more which were not included in the client survey but deserve some discussion. These include some which will be discussed in the following sections.

A major hurdle to for accessing programming of the aged is transportation. Many older individuals no longer drive or have the resources to own and keep up the ownership of a vehicle.

The Senior Recovery Program provides transportation, free of charge, to participants in a 15 mile radius of the center. This is a huge benefit and encourages fulltime participation by clients.

This aspect of the program was not explored within the survey but likely has an impact on clients who are not able to drive or choose not to drive any longer.

Another factor which contributes to the success of the Senior Recovery Program is the staff and volunteers who work at the center. The staff includes Licensed Alcohol and Drug Counselors (MA, Psy D and LADC), Social Worker (MSW), a Programs Director, an Executive Director and several interns and volunteers. The vast experience of the staff contributes greatly to the Senior Recovery Programs success. The training and licensing of the staff ensures they are employing the best practices in regard to chemical health treatment for the aged. The consistent evaluation and quality insurance checks provide feedback to the program directors which allow change to occur which ensures quality treatment within their programming.

The clients who access the program indicated through survey feedback that they really enjoyed participating in the programming provided by the center. The Director of Programs provides a wide variety of events which include guest speakers who present on varying topics of interest to seniors. Topics have included nutrition, retirement planning, and mindfulness. Other activities include potluck lunches, electronic games (Wii), bingo, arts and crafts. The clients who participated in the survey indicated they would like more programming during weekend hours and longer hours of operation.

As much of the previous literature, and findings from this program evaluation indicate, that substance abuse treatment programming for older adults should be designed with the specific needs of older adults in mind. Those practicing with older adults experiencing substance abuse issues need to be cognizant of specific needs concerning assessment and intervention

methods suitable for this particular group.

Through this brief program evaluation of the Senior Recovery Program it was clear what some specific needs should be addressed when providing substance abuse treatment programming for older adults, these include but are not limited to the following: Age guidelines (age 50 and over); Transportation to and from the treatment location; Socialization activities (game days, arts & crafts); Educational experience (how alcohol and drugs intermingle with the body as an older adult vs. younger); Weekend programming.

This program evaluation was limited in its small sample of 27 total participants of the approximate 55 attendees on the survey event date. The small number of participants, coupled with their race, income, gender and geographic homogeneity, could make it difficult to generalize the findings to other populations. Further study would be needed to ensure that similar results are seen in larger and more diverse groups of older individuals. A larger sample size would most likely show more significant results.

Due to the sensitive nature of this study, participation was limited to those individuals who are current participants in activities provided at the Senior Recovery Program location. The limited design of the study did not allow for methods of contact to be made through such means as mailings due to confidentiality issues. Those who completed the program and are not presently participating in activities provided at the Senior Recovery Program may have different opinions of the Senior Recovery Program. One must consider the possibility that only the people who did well in the Senior Recovery Program were willing to participate in the survey. Those former clients who did not complete the Senior Recovery Program or were not satisfied with the services and those who were unable to be located to be selected to be in the sample were not

represented in this program evaluation. Further study would be needed of prior client's to ensure results are accurately reflecting client satisfaction of the Senior Recovery Program.

Both assumptions and expectations regarding the aged and substance abuse were met with both surprise and disappointment. I had expected to find that there are several programs which cater to an older population with substance abuse issues. However, this was not the case, the researcher had expected to find much more literature comparing age specific programs and social system improvements to address this hidden epidemic.

These thoughts and expectations of the researcher may be influenced by her professional experience working as a Geriatric Care Manager Intern, where she was exposed to very innovative healthcare programs which addressed the needs of elderly individuals. Additionally, Minnesota is a state which is known for its recovery programs and is known as "recovery friendly" state where substance abuse programs are typically innovative and plentiful.

Implications of Current Research for Social Work Research

Practice knowledge and research about this issue are poorly developed; however, the information provided by this program evaluation will contribute to the existing pool of information. Nevertheless, the lack of empirical data relating to older adults and substance abuse treatment programming begs for future attention. Social workers are well positioned as the frontline defense to not only diagnose but to also to provide the most appropriate treatment options for these individuals who deserve to live their last years with peace and clarity.

It is vital that social workers consider the impact of substance abuse in their older clients, as these have devastating impacts on their quality of life. Decreased functioning, multiple health concerns, and loss of social contact are just a few consequences of untreated substance abuse. Although diagnosis of substance abuse is more difficult in older adults, accurate assessment

remains a precursor to effective treatment planning. Education is a must by social workers to accurately use the available assessment tools and plan effective treatment interventions. Social services and health care must creatively blend the present knowledge and clinical needs to develop responsive and effective interventions. Additional research is needed to determine the quality and accuracy of assessment tools and the types of interventions that are best suited for older clients whom are experiencing substance abuse issues.

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Appendix A
CONSENT FORM
UNIVERSITY OF ST. THOMAS
GRSW682 RESEARCH PROJECT

The Senior Recovery Program (S.P.E.C. Program)

I am conducting a study to evaluate the Senior Recovery Program (S.P.E.C. program) and how effective the program is at meeting its goals through the eyes of its participants. I invite you to participate in this research. You were selected as a possible participant because of your experience of participating in the Senior Recovery Center SPEC Program. Please read this form and ask any questions you may have before agreeing to be in the study.

This study is being conducted by: Lisa LaCoursiere, a graduate student at the School of Social Work, St. Catherine University/University of St. Thomas and supervised by Dr. Felicia Sy, Ph.D., LICSW.

Background Information:

The purpose of this study is to evaluate the S.P.E.C. program and how effective the program is at meeting its goals through the eyes of its participants. The purpose of this assignment is to provide an opportunity for me to demonstrate my knowledge, skill and understanding of the quantitative research process using a topic of my interest.

Procedures:

If you agree to be in this study, I will ask you to do the following things: Participate in a written survey which will take approximately 10-20 minutes; I will analyze the survey data; present findings orally; and write a report of the findings.

Risks and Benefits of Being in the Study:

The study has limited risks.

The study has no direct benefits.

Confidentiality:

The records of this study will be kept confidential for this study. As a classroom protocol, I will not publish any of this material. Research records will be kept in a locked file at my residence. I will also keep the electronic copy of the data in a password protected file on my computer. Findings from the survey data will be presented orally in a public forum. The survey data will be destroyed by June 1, 2013.

Voluntary Nature of the Study:

Your participation in this study is entirely voluntary. You may skip any questions you do not wish to answer and may stop the survey at any time. Your decision whether or not to participate will not affect your current or future relations with St. Catherine University, the University of St. Thomas, or the School of Social Work and the Senior Recovery Center. If you decide to participate, you are free to withdraw at any time without penalty. Should you decide to withdraw, data collected about you will not be used.

Contacts and Questions

My name is Lisa LaCoursiere. You may ask any questions you have now. If you have questions later, you may contact me at 612.270.6061 or Dr. Felicia Sy, Ph.D., LICSW at 651.962.5813. You may also contact the University of St. Thomas Institutional Review Board at 651-962-5341 with any questions or concerns.

You can keep this copy of the form for your records.

Statement of Consent:

I have read the above information. My questions have been answered to my satisfaction. I consent to participate in the study by filling out a prepared survey questioner.

Signature of Study Participant

Date

Signature of Researcher

Date

Thank you.

Appendix B

Senior Recovery Client Evaluation

Please read each item below and circle the response that most closely matches your answer.

1.	Since being involved in the Senior Program, my alcohol/drug usage has:	Stopped	Decreased	Stayed the Same	Increased
2.	The Senior Program has given me the tools to help me maintain my sobriety.	Strongly Agree	Agree	Disagree	Strongly Disagree
3.	I believe I can Maintain my sobriety.	Strongly Agree	Agree	Disagree	Strongly Disagree
4.	I have maintained positive support Networks with my peer.	Strongly Agree	Agree	Disagree	Strongly Disagree
5.	It is important to me to socialize with others on a regular basis.	Strongly Agree	Agree	Disagree	Strongly Disagree
6.	Staff encourages me to spend time socializing with others.	Strongly Agree	Agree	Disagree	Strongly Disagree
7.	The Senior Program has helped me achieve a healthy lifestyle.	Strongly Agree	Agree	Disagree	Strongly Disagree
8.	It is important to me to have a positive relationship with my family.	Strongly Agree	Agree	Disagree	Strongly Disagree
9.	Staff have helped me communicate more openly with my family.	Strongly Agree	Agree	Disagree	Strongly Disagree
10.	My family supports my sobriety.	Strongly Agree	Agree	Disagree	Strongly Disagree
11.	Senior Program staff helped me achieve a better quality of life.	Strongly Agree	Agree	Disagree	Strongly Disagree
12.	I ask for help when needed.	Strongly Agree	Agree	Disagree	Strongly Disagree
13.	I was given sufficient individual attention from staff.	Strongly Agree	Agree	Disagree	Strongly Disagree

14.	Senior Program staff seemed to understand my situation.	Strongly Agree	Agree	Disagree	Strongly Disagree
15.	I felt strongly supported by staff.	Strongly Agree	Agree	Disagree	Strongly Disagree
16.	Senior Program staff care about me.	Strongly Agree	Agree	Disagree	Strongly Disagree
17.	I am satisfied with the level of services offered by the Senior Program.	Strongly Agree	Agree	Disagree	Strongly Disagree
18.	What do you like best about the Senior Recovery Program?				
19.	What would you like to see improved or changed about the Senior Recover Program?				
20.	Are you:	Male		Female	
21.	What is your race or ethnicity?	African American or Black Latino or Hispanic	American Indian White or Caucasian	Asian or Pacific Islander Other	
22.	What is your age?				
23.	What is your income per year?	Under 15,000 15,000-20,00 20,000-30,000 30,000-40,000		40,000-50,000 50,000-60,000 60,000-70,000 More than 70,000	
24.	What is your living status?	Live Alone		Live with Others	

25.	What is your marital status?	<p>Single</p> <p>Married</p> <p>Divorced</p>	<p>Separated</p> <p>Widowed or Widower</p>

Thank you!

Appendix C



December 1, 2012

Lisa LaCoursiere
7632 1st Avenue South
Richfield, MN 55423

Dear Lisa:

Thank you for meeting with me to discuss your studies in the Masters Program in the School of Social Work at the University of Saint Thomas. I am pleased to confirm that you have the support of the Senior Recovery Center in surveying our S.P.E.C. Program former clients in support of your research project: Program Evaluation (SPEC Program).

I understand that your study is a program evaluation that will invite our former S.P.E.C. Program clients to participate in an anonymous survey. The former clients invited to participate will have the opportunity to participate or decline the survey. I am happy to allow our former clients to receive the survey at the Senior Recovery Center which will yield the best results and ensure the clients anonymity. I understand that the survey is anonymous and will be distributed and explained by our Program Director and in the written instructions. I appreciate that you will implement appropriate measures to protect the confidentiality of all participants and that all reports and presentation will protect the confidentiality of the research participants as well as the organization.

I understand that you will not proceed with your research until you have obtained the approval of your clinical research committee and the Institutional Review Board at the University. I also understand that your research project is a part of our clinical research paper which will be published and presented in a public forum.

I do not anticipate any direct benefit or risk to our organization or to our participating clients. However, I certainly believe that there will be indirect benefit from your research, in that you will be adding to the knowledge base in the field of social work in an important area of study that has received very little attention.

Sincerely,

Kim W. Jenkins
Executive Director