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Screening techniques : clinicians' views and approaches to assessing alcohol and substance use in older adults

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ABSTRACT

This qualitative study examined how New York State licensed clinicians approach the initial assessment and ongoing treatment of older adults (55+) identified to be struggling with alcohol or substance misuse issues. The research questions specifically asked: Do clinicians assess for alcohol and substance misuse in the older adult patients they serve? What are the mediating factors within this assessment and treatment process? This study was initiated in an exploratory fashion because of the limited amount of research available which investigates the relationship between clinicians' attitudes and approaches to this work with the rapidly growing older adult populations they serve.

Given the constricted amount of literature available on this topic, a phenomenological approach was employed. Twelve licensed mental health clinicians, practicing for at least a year in the New York City Metropolitan area, were telephonically interviewed. The demographic characteristics of each are organized in Appendix E, and further expanded upon in the findings and discussion sections of this research report.

In line with a phenomenological approach, the thematic analysis of participants' responses was employed. The findings produced a depiction of therapeutic practice aligned with the available research: (1) clinicians often minimize assessment of alcohol and substance misuse practices in ever-growing older adult populations; (2) clinicians report a lacking standardization of preventative protocol for the assessment of alcohol and substance misuse in older adult populations; and (3) the therapeutic methods

employed by clinicians in consultation with older adults, are viewed as needing the appropriate modifications in order to better provide comprehensive mental health treatment.

SCREENING TECHNIQUES: CLINICIANS' VIEWS AND APPROACHES TO ASSESSING ALCOHOL AND SUBSTANCE USE IN OLDER ADULTS

A project based upon an independent investigation, submitted in partial fulfillment of the requirements for the degree of Master of Social Work.

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CHAPTER I

INTRODUCTION

Existing research demonstrates that older adults are at risk of alcohol and substance misuse and abuse (Barry, Blow, Oslin, 2002; Brennan, Moos, Moos, Schutte, 2010 & Oslin, 2006). Substance abuse is understudied in the research literature on older adults (Jeste & Patterson 1999). While existing research demonstrates a need for early screening and assessment of substance misuse and/or abuse among older adults, substance abuse screening for older adults is perhaps often minimized (Menninger, 2002; Widlitz & Marin, 2002). Furthermore, few studies aim to capture the experiences of service providers *themselves,* to understand current practices in substance screening for older adults, as well as the barriers that may preclude practitioners' comprehensive assessment of substance abuse with older adult populations.

There is no question that the elderly population is increasing at a rapid speed. According to the U.S. Bureau of the Census (2000), the population of people aged 65+ in the United States will double from 35-70 million over the next 25 years due to the aging of the baby boomers. In the United States, the percentage of older adults will increase from 13-20% of the population. More specifically in New York State, the number of older adults aged 65+ will increase by 50% over the course of the next quarter century (from 2.4-3.7 million). With this rapid increase in a subset of the population that has traditionally never been so large, an imbalance in service provision is inevitable and fast approaching.

As social workers we are called to quickly fill this gap and lack of service provision, especially in regards to the projected necessary changes in *types* of service provision coming forth. In 2004, the Department of Health and Human Services released a study predicting that

substance abuse problems among older adults would increase 150% by 2020. We have already begun to see these shifting trends as the most recent SAMHSA data (2010) indicates that from 1992-2008, rates of admissions to substance abuse treatment by older adults increased from 6.6% to 12%. As service providers or family members are at the forefront of referral source concerning issues such as these, it might be possible that awareness has become more prevalent regarding older adults' substance misuse and/or abuse. However, this increased percentage of those receiving treatment is far from all-encompassing. With the anticipation of immense population growth among older adults, it will rapidly become even more imperative to go beyond *awareness* of the issue, and apply (as well as research methods) advances in screening tools and service provision within the practice of our work. The goal of this research was to look at current trends in application (if any) of advanced screening techniques for substance abuse and/or misuse, as utilized by clinicians in the field – how are they assessing for these matters in their daily practice?

The purpose of this study is to explore clinicians' use of advanced screening and assessment techniques for substance abuse and/or misuse with older adults. Specifically, I became interested to learn more about how clinicians perceive the use of substance abuse screening with older adults; and furthermore, how they utilize and understand substance abuse screening and assessment practices with the older adults they serve. This qualitative research project sought to answer the following questions: What are clinicians' assessment and screening practices for substance abuse with older adults? How do clinicians screen for substance misuse and/or abuse among older adults? What are clinicians' experiences of utilizing substance abuse screening and assessment tools in their clinical practice with older adults? How do clinicians who are working with older adults understand the need for substance abuse screening and

assessment with a population of older adults? What are the perceived barriers to utilization of substance misuse/abuse screening measures in clinicians' assessments of older adults? To answer these questions I conducted a series of individual telephone interviews with twelve clinicians practicing with older adults in the New York City metropolitan area.

This study has important implications for social work practice and program development with older adults at risk of substance misuse/abuse. Early screening and assessment of substance abuse and/or misuse with older adults is important for the development of prevention and treatment programs for older adults. It is important for social workers to identify the signs and symptoms of substance misuse early in the lives of older adults in order to prevent occurrences of abuse among this understudied population.

CHAPTER II

LITERATURE REVIEW

Alcohol and substance abuse among the elderly population are increasingly growing problems and require close attention. Substance abuse and/or misuse may refer to a myriad of issues including mood altering drugs, drinking erratically, or unsafe use of prescribed medications, among others. According to reports in the *Journal of the American Medical Association (JAMA)*, about 50% of individuals with serious mental disorder are also affected by substance abuse. Thirty-seven percent of alcohol abusers and 53% of drug abusers have at least one serious mental illness; and 29% of individuals diagnosed with a mental illness abuse drugs or alcohol. The dangers of drug and alcohol abuse in the elderly are extensive. This reality is due to the fact that the body changes as it ages, causing slower metabolism, decreased tolerance to alcohol and some medications, and even hypersensitivity to substances at times (Menninger, 2002; Shibusawa, 2006). Alcohol abuse in old age may result from years of drinking in earlier adulthood or may be triggered by social isolation, financial woes, bereavement, role changes, and other challenges that occur during transitions through later adulthood.

As a way to lay the framework for this chapter, I will begin with a description of the transitions and stages of development one might undergo through older adulthood. The second section, alcohol abuse/misuse screening instruments, will provide an overview of the assessment tools currently available for reliable application by medical and mental health professionals practicing in the field. I will expand upon how these assessment tools are used, and highlight some areas wherein which the assessments prove to be inapplicable to older adults (55+). These gaps in assessment will further be explored in the third section, challenges for mental health professionals, and carry through into the forth section of literary justification, barriers for older

adults. To conclude this chapter, I will outline a comprehensive rationale for the exploratory research findings produced in this study.

Aging: Stages of Development

Aging in humans refers to the multidimensional process of psychological, social, and physical change. This process is an important part of all human societies as it not only reflects the biological changes that occur over time, but also the cultural and societal conventions of a generation and era. It has been estimated in the literature that roughly 100,000 people worldwide die each day of age-related causes such as Alzheimer's disease and major cardiovascular diseases (De Grey, 2007). Age is measured chronologically, and a person's birthday is generally an important event. However, the term, *aging*, itself can often seem quite ambiguous when used to quantify "universal aging," "probabilistic aging," and "distal or societal aging." Evaluations like these attempt to provide a perspective through which we can begin to categorize variation over the course of the aging process. Throughout the literature, *universal aging* is meant to describe the sort of age changes that all people share. *Probabilistic aging* quantifies the age changes that may ensue for some, but not *all* people as they age older – an example being Type Two diabetes (Berkman, B. 2006). Finally, *distal* or *societal aging* has been cited amongst the clinical community of geriatric researchers in reference to society's expectations of how people should act as they grow older (De Grey, 2007; Marin & Widlitz, 2002). The chronological number itself seems to become most important as we delineate between the subsets of coined older adult and aging progressions through middle and end of the human life cycle. For the purpose of this research study, our socialized understandings of various aspects of *distal aging* serve as a framework for the bulk of attitudes and perspectives present in the consulting room with older adults and all clients we serve alike.

Differences are often cited throughout the literature that demarcate between *young old* (65-74), *middle old* (75-84), and the *oldest old* (85+) (Berkman, 2006; Brennan, Moos B., Moos R., & Schutt, 2010). The Substance Abuse and Mental Health Services Administration (SAMSHA) generates a majority of their data, however, with the understanding that an *older adult* is someone 55 and over. This age cutoff ensures that any data produced will be an accurate picture of an older adult population including "baby boomers" (the largest aging cohort). I chose to screen for inclusion, those clinicians working with older adults (defined as 55+) for this reason. In order to provide comprehensive care for this aging generation, we must start to detect and address concerns of alcohol and substance abuse/misuse early on.

Alcohol Abuse/Misuse Screening Instruments

Alcohol abuse by older adults is less prevalently reported than in younger populations. It is more difficult to detect, particularly because it is in the workplace where alcohol and drug problems are frequently detected or screened for (Shibusawa, 2006). There are several alcohol abuse screening tools available for use by health care professionals. The *Short Michigan Alcoholism Screening Instrument (MAST-G)* was the first screening instrument developed for use with older adult populations. The MAST-G is a 24-item tool that helps detect alcohol use in older adults. Another instrument that is more commonly used to screen for alcohol abuse is the *CAGE Screening Questionnaire.* This is a four-question instrument that gages an individual's drinking habits. However, the CAGE Screening Questionnaire relies solely on self-report so it is difficult to determine its validity. A third instrument is the *Alcohol Use Disorders Identification Test (AUDIT)* which is a 10-item survey that measures negative alcohol-related consequences and descriptions of total alcohol consumption.

Menninger (2002) found the MAST-G to be more sensitive than AUDIT for identifying alcoholism in older adults. The use of these instruments alone will not suffice in the detection of all prevalent alcohol and substance abuse in older adults. In addition, health care professionals should be on the look-out in an on-going assessment for risk factors such as depression or anxiety, loss and bereavement, social isolation, chronic pain, loss of physical mobility, loss of partner or employment, retirement, or the onset of a new care giving role while working with older adults (Brennan, Moos B., Moos R., & Schutt, 2010; Shibusawa, 2006; Widlitz & Marin, 2002).

Challenges for Mental Health Professionals

Screening for substance abuse among the elderly may be challenging for health care professionals due to the fact that many older adults take some sort of medication (or a compilation of many) to help manage chronic illnesses. Primary care doctors are generally at the forefront of screening and referral for conditions such as substance abuse. This is why it is so important that there is a consistent overlap between the fields of mental health care and primary care. Despite the wealth of information and screening tools on the epidemiology and treatment of alcohol abuse in older adults, not much comparable data are available on prescription drug abuse in this population. In the limited studies available, prevalence varies according to the population and the substances under investigation. A recent study conducted in a geriatric outpatient clinic showed overall prevalence for any substance use disorder to be 20%; prevalence of alcohol-dependence to be 8.6%, and prescription narcotic dependence was 1.4% (Widlitz & Marin, 2002). A study of 565 consecutive geriatric psychiatry admissions to a Veterans Affairs medical center found that 11 of 18 patients diagnosed with a prescription drug use disorder had also struggled with an alcohol-related disorder at some time in their lives (Lemke & Schaefer,

2010). The sample included alcoholism in remission in 6 of 16 patients with current benzodiazepine-use disorders. These findings suggest that substance use disorder in the geriatric population exists to a greater extent than previously reported, and that this may represent a transition from alcohol to benzodiazepine misuse and/or abuse as facilitated by physicians' greater tendency to prescribe them to older patients (Bergkvist, Eriksson, Hoglund, Larsson & Midlov, 2009). But are mental health and medical practitioners observing this trend? The National Survey on Drug Use and Health (2009) projections suggest that in 2020, *non-medical use* of psychotherapeutic drugs among baby boomers will increase from 1.2% (911,000) to 2.4% (2.7 million). Detection and treatment of such an invisible epidemic will be pertinent work for those novice and long-standing clinicians in the fields of health care, human services, and the like.

Barriers for Older Adults

Keeping the above in mind, providers must realize that older adults are faced with several barriers when trying to access certain viable health care services (most specifically mental health). The subsets of the population that faces the greatest struggle are those elders of Color, particularly African Americans and Latino older adults (Kelsey & Laditka, 2009). The barriers are faced at the systemic, agency, and individual levels. By examining each type of barrier, health care providers may be able to better understand why so many elderly do not receive necessary treatment.

The systems of Medicare and Medicaid funding are often daunting and *beyond* confusing to those attempting to access services. Within agencies, a perpetual stereotype can emerge, often holding older adults as poor candidates for mental health services (Oslin, 2006). Healthcare providers who practice with a perspective and lens for distal or societal aging (which holds the

socialized ideals that depression and anxiety are simply "normal" aspects of aging) can deter initial screening or further assessment and treatment for those patients who need it most (Mcinnes & Powell, 1992; Oslin, 2006). In general, the homebound are far less likely to receive treatment because of the overall shortage in community-based outreach services in the New York metropolitan area. This, coupled with the varying generational ideologies about seeking treatment (specifically mental health treatment), renders a substantial force that each healthcare professional must overcome in the clinical detection and treatment of substance misuse and/or dependence (Barry, Blow, & Oslin, 2002).

Rationale for the Current Study

Breaking down the barriers that confront many older adults with respect to allocation of services is essential. The findings of this study may provide critical information for the development and implementation of screening techniques geared specifically to the ever-growing older adult population. Research studies like this serve as a gateway for the provision of more comprehensive supports and treatment for older adults who struggle with substance misuse and dependency issues. Although it is difficult to identify and treat older adults with concerns such as alcohol and substance abuse, research indicates that once elders are in a therapeutic treatment setting they have better outcomes than younger adults (Benza, Calvert, McQuown, 2010; Bernabei, Gambassi, Landi, Mor, Sgadari, & Zuccala et al. 1998). Evidence-based treatments such as Cognitive Behavioral Therapy (CBT), when tailored to the specific needs of older adults, have been proven effective in treating alcohol and drug abuse among the population (Barry, Duchene, Etheridge, Herrerra, King-Kallimanis, & Schonfeld, et al., 2010; Bergkvist, Eriksson, Hoglund, Larsson, & Midlov, 2009). The goal of the current study is to explore clinician's experiences in their professional utilization of substance abuse screening tools and techniques

with older adults. In particular, how it is that clinician's perceive the use of substance abuse screening with diverse populations of older adults; and, furthermore, how they understand the need for substance abuse and/or misuse screening in their clinical assessment practices with older adults.

In order to develop and implement effective programs for older adults at risk for substance misuse and dependency, it is helpful to assess and understand the practices currently in place, as well as those techniques or tools being utilized among clinician's in the field. In addition to offering insight about these current practices, the following data analysis has value for understanding the potential barriers to implementation of substance abuse screening and assessment techniques with patients who are understood to be older adults.

CHAPTER III

METHODOLOGY

The overarching research question for this study is: What are clinicians' attitudes and perspectives towards assessment of substance misuse in the populations of older adults they serve? In order to develop and implement effective programs for older adults at risk for substance misuse/abuse, it is helpful to assess and understand the practices currently in place and those utilized among clinicians as a way to understand substance abuse risks among older adults. This is exactly what I attempted to do within the constructs of this qualitative research design. In addition to offering insight about current assessment practices, this study may have value for a more comprehensive understanding of the potential barriers to implementation of substance abuse screening and assessment with elderly service users.

Research Design

Given the review of the literature, it became quite apparent that a knowledge base of clinicians' assessment practices with regards to alcohol and substance misuse in the older adult populations was unavailable. As this topic of concern was further explored, a qualitative method of assessment appeared most relevant for the purposes of this data collection and analysis. I saw that within the literature, our profession needed to develop a deeper understanding of this phenomenon and its subjective meanings as it occurs in everyday life, while simultaneously holding an emphasis on the social context of the observations of theme (Babbie & Rubin, 2009). Qualitatively oriented research afforded me the freedom and flexibility to explore the most salient variables and their deeper meanings as they organically emerged in my data collection. The semi-structured interviewing techniques I employed further elicited the collection of detailed descriptions from multiple perspectives, and helped to highlight inductively this clinical

approach that was previously poorly understood and undocumented in the literature (Anastas, 1999).

I selected my sample in a purposive and non-probable manner. From the larger sample of referrals, I screened for a heterogeneous mix of mental health clinicians with at least one year of experience in the field. Ongoing contact for recruitment was handled via email, and interviews were conducted via telephone. The interview guide was comprised of semi-structured, open-ended questions as a way of gathering narrative data, and participants were entered into a drawing for a $25 Barnes & Noble gift card (if desired) upon completion of the interviews.

Sample

Recruitment for this study came from a pool of clinicians working throughout all five boroughs of New York City. The sample consisted of 12 clinicians, who agreed to participate in individual telephonic interview sessions. Screening of potential participants was done in a purposive manner to include those clinicians who are licensed and practicing for a minimum of one year in community outreach or outpatient agency settings. I sought to include those professionals most involved with the screening process of incoming clients, and I also attempted to gather participation from both agencies that designated a specific screening protocol and "team," along with those agencies that do not. Additionally, I sought out those clinicians who carried some older adults on their current caseloads.

Any clinicians who were licensed and certified as geriatric care managers were excluded from this sample pool. This specialty (geriatric care manager) and service is available to those older adults that are able to pay for private services out of pocket; generally serving more of a homogeneous population of middle to higher socioeconomic status older adults. I excluded this specialty licensure because of the comprehensive review that is already housed within the

protocol implemented through the services of these private practices and agencies. The private agencies that employ geriatric care managers allow billable hours for a comprehensive assessment, within which is an intensive rubric intended to assess alcohol and substance abuse/misuse of older adults. Based on the results of this study it is a viable possibility that a tool of assessment could emerge for the agencies *without* a standard and thorough protocol for assessment of substance use in older adult populations. The services provided by geriatric care managers already include a comprehensive geriatric assessment that is not afforded to the average older adult interfacing with medical and mental health services.

Recruitment

As previously mentioned, the recruitment of participants for this research project consisted of a purposive sample of twelve clinicians. Clinicians were recruited through a combination of convenience and snowball sampling from community based mental health organizations serving older adults in the New York City Metropolitan area. The primary recruitment site from which I gathered participation is through public data posted on the NASW website (www.naswnys.org). On the NASW page, links were provided for affiliated "social worker search engines" through facebook.com, Helppro, and Social Work Finder. Recruitment for this study was accomplished via a recruitment email (Appendix A) and telephonic outreach. I had found that on these public media web-pages and searches, it is often common for a clinician to post their telephone number, but not always their email address. For this reason I chose to first reach out to clinicians via telephone. If they showed interest in my study and satisfied the inclusion criteria I supplied them with the supplemental recruitment flyer via email, as well as an attached copy of the informed consent. I additionally scheduled a telephonic interview with clinicians at this time – a 30 minute time block where the clinician was audio-

taped and asked to provide some demographic and background information, as well as respond to a mixed battery of interview questions (Appendix B).

Ethics and Safeguards, Risks and Benefits

It was anticipated that there was no greater than minimal risk for participation, which held true throughout the collection and analysis of all data. All identifying information privy to primary researcher was held in confidence. Participants stayed true to their social work code of ethics as they actively engaged in this research process. All clinicians involved in this study have added to a subset of the literature which is of high importance at this time. Presently clinicians are seeing a rise in the population of older adults we serve (many prescribed medication that can easily be misused and render addiction). This exploratory study holds the potential to enhance our understandings regarding clinicians' perceptions of roles and activities in this increasingly important area of practice. A new way to evaluate and care for these older clients could soon emerge and bolster a stronger set of preventative measures in the field of social work – a new screening tool could be devised as a result of the knowledge and techniques explored. It should also be noted that clinicians involved in this research study were given the option of entering in a drawing for a $25 Barnes & Noble gift card.

Protecting Confidentiality

All consent forms collected were kept separately from audio tapes of the sessions, locked in a private confidential cabinet along with all flash drives containing any electronic data which includes code numbers. Additionally, participants were reminded not to use names or any identifying information when talking about their clients. Confidentiality has been upheld throughout the production of results. Names and code numbers have been omitted from the final thesis write-up, as well as future presentations and publications of the data. In addition, it should

be noted that my research advisor was the only person, other than myself, that had access to the raw data; and only after identifying information had been removed. All data and tapes resulting from the interviews will be kept in a secure place for three years as required by Federal regulation. After that time they will be destroyed or continue to be kept secured as long as the tapes and data are needed for this research project. When no longer needed, the data will be destroyed.

Data Collection

Research participants were first asked to read and sign the informed consent (Appendix C). Clinicians who agreed to be a part of the study were asked to participate in a single, audio-taped interview. Each telephonic interview lasted approximately 30 minutes, and every participant was invited to submit their name for entry in the randomized drawing for a $25 Barnes & Noble gift card. Participants were asked to provide some demographic and background information, and then further discuss their substance abuse screening and assessment practices with older adults. I designed an interview protocol for the proposed study (Appendix B) that served as a guide in conducting interviews. Participants were asked to openly discuss those techniques and practices utilized when screening their clients for substance abuse/misuse behavior upon initial, and throughout ongoing assessment. Participants were asked to share their perception, attitude towards, and definition of substance abuse/misuse in the populations of older adults they serve. Each interview was conducted in a confidential manner as only the primary researcher was aware of participants' identities.

Instrument

The set of interview questions that was used for the purposes of this research project first emerged through a collective brainstorm with my thesis advisor, following a review of the literature. The questions were initially intended for use in a series of focus group sessions, and were then slightly modified for the purposes of individual interviews. This interview guide (Appendix B) was piloted on two separate occasions to the same two people – one a licensed clinician, and the other a financial analyst by profession. Both individuals involved in piloting were excluded from the sample population. Constructive feedback was incorporated in the revisions of the interview battery.

Responses to all questions posed during the interview were recorded and later transcribed. Questions were presented in an open-ended form, and additional probes were used to elicit details and clarify the specifics of certain assessment protocol described. Examples of interview questions included: "What does substance use look like in older adults? How often does it show up? What forms has it taken in your work?" and "What is your personal approach to screening for alcohol and substance use/misuse when working with older adults?" Overall questioning was directed to capture an analysis of clinicians' personal demographic characteristics and the characteristics of the client population they serve; the assessment and screening techniques clinicians' use in practice; and finally their approaches to treatment of older adults struggling with alcohol or substance misuse/abuse.

CHAPTER I V

FINDINGS

The open-ended questions focused on the attitudes, practices, and approaches to the assessment and treatment of substance abuse in elder clients by twelve licensed clinicians practicing in the New York Metropolitan area. The transcriptions of all interviews were subjected to a content-theme analysis. The data collection and analysis procedures provided an opportunity to identify emergent categories within completed interviews, and to explore these categories further with future respondents. As the data was continuously analyzed, both during and between the participant interviews, space was allowed within the questioning for further exploration of the most salient research questions. For example, after the first two interviews, it was apparent that participants had a lot to say about the screening and assessment questions housed within the interview protocol – participants did not have as much to say about their preferred approaches in the treatment of older adults. As this research was conducted through the utilization of the phenomenological stance, it was possible then to frame the questions related to treatment approach more particularly as directly related to the clinicians' responses given for the assessment and screening practices employed. The major findings that emerged were in relation to the day-to-day life and practices of each clinician.

The demographic characteristics of the clinicians in the sample are organized in a table presented in Appendix D. Although the professional credentials of each clinician are not comprehensively outlined here, there emerged an overwhelming consensus that the clinician's specialization within the substance abuse framework (ie. as a Substance Abuse Practitioner), served as a major factor for both *assumed* and self-reported comfort in assessment and treatment practices while working with older adult populations. Additionally, the overall response of

participating clinicians highlighted the importance of a practice in clinical settings that foster ongoing supervision and trans-disciplinary collaboration amongst mental health and medical professionals alike while working with the older adult patient. In an assessment of clinicians' approaches to the treatment process, all twelve therapists felt they would be better equipped to assess and treat older adult patients struggling with substance misuse and/or alcohol abuse, if they were able to collaborate with medical professionals.

The first section of this chapter presents an overarching description and report of the demographic characteristics of the clinicians interviewed. The second section describes the characteristics and reported demographics of the client populations served by these clinicians The next two sections focus on the assessment and screening techniques employed in clinical practice with older adults, followed by the reported approaches used in ongoing treatment. The chapter ends with a comprehensive summary and overview of the findings for this exploratory research prior to an expansive discussion of its implications.

Demographic Characteristics of the Clinicians

The interview guide began with a demographic assessment of each clinician. Appendix D contains the table of the demographic characteristics outlined here. Of the 12 clinicians interviewed, eight self-identified as females, while the remaining four identified their gender to be male. Half of the participants used the term *heterosexual* as an identifier, and four others described themselves as same gender-loving (two *gay* and two *lesbian*), when asked about their sexual identities. Two participants refrained from answering this demographic question entirely.

All clinicians are currently licensed social workers practicing within the New York Metropolitan area – five practicing within the borough of Queens, three in Brooklyn, and four others in Manhattan. The range in reported years of experience as practicing social workers was

large in scope (between two and 26 years), with a median calculation of roughly 11.8 years in licensed practice. Ten of the 12 clinicians interviewed are currently in private practice, while the remaining two identified agency affiliations and titles.

A subsequent section of the demographic questionnaire attempted to categorize participating clinicians based on their racial and ethnic identities. Seven clinicians racially identified as white, two as African-American, two as black, and one as Hispanic. When asked to provide a quantifying ethic identity in succession, a range of responses emerged. Both clinicians who reported their racial identities as African-American coined their ethnicities to be *black.* Two out of the seven racially self-identified white clinicians reported their ethnicities as Caucasian, and an additional two ethnically identified as Irish. The six remaining clinicians uniquely reported their ethnicities as follows: Northern European, Indian, Dominican, Guatemalan, Italian, and African-American.

As a way to conclude this portion of demographic questioning, interview protocol entreated clinicians, "Please describe any additional credentials, certifications, or professional specializations that are of particular relevance to serving the older adult populations in question." Respondents unanimously explained that their answers to this question were stunted, but out of the unique professional histories presented by each, a surprisingly consistent series of affiliations and commonalities emerged. Five of the 12 clinicians identified as registered nurses. Each of these explained that this was their "…chosen profession prior to the pursuit of a career in social work." Three of these five interviewees, and eight in total, identified as credentialed alcohol and substance abuse practitioners with the Office of Alcoholism and Substance Abuse Services (OASAS) in New York State. Two of those clinicians credentialed through OASAS (one additionally as a registered nurse, and the other not) also reported practicing as Substance Abuse

Professionals (SAP) with the United States Department of Transportation. And finally, two of the participants abstained from answering this question entirely.

Characteristics of the Client Populations

As the interview rubric shifted to focus on the salient identifiers of the older adult clients that the interviewees currently serve, a parallel experience of consistency in response materialized. One closed and one open-ended question was asked of each clinician: How are older adult clients (55+) referred to your practice setting? What are the major identifying characteristics of these clients? Clinicians were given the freedom to expand upon whichever identifying characteristics they interpreted as most relevant to their current work with the older adults in question.

Referral sources

Those respondents currently working in a private practice setting (10 of the 12 individuals interviewed) presented a range of response with regards to referral sources. Most of these licensed clinicians, although classified as "practicing privately," emphasized that they do so within a setting shared amongst other *privately practicing* professionals (psychiatrists, psychologists, nurse practitioners, and the like). In addition, all ten of these clinicians noted an extended network and collaborative relationship with healthcare professionals spanning across the New York Metropolitan area. With this factor presented as the norm by all ten clinicians, it follows that a consistent response with regards to referral source emerged. Collegial referral within the same setting ranked highest as initial source of introduction to the older adult patients these clinicians serve; outside referrals were described as highest from collaborating psychiatrists from the community, Client were also referred from via primary care physicians and internet sources (much like the search engine sources utilized in the methodological protocol

of this research study). The two interviewees that reported their current practice to be in affiliation with agencies, described a much more calculated and consistent source of referral. Both clinicians reported that, "…referrals generally come from our state and county funding sources – any older adult being monitored by adult protective services usually requires our collaborative treatment and assessment." Additionally, these agency affiliated clinicians noted a small pool of referrals originating from community-based homeless shelters.

Client Caseloads and Characteristics

The average number of older adult patients currently carried on each clinician's caseload was approximately four – ranging anywhere from two to twelve older adults (55+) in treatment with each clinician at the time of interview. The age range of these clients was noted by participants as spanning from 55 – 82 years old. All clinicians noted that older adults who identified their gender as male, to be in the highest percentage of referral for alcohol and substance misuse/abuse treatment; or to enroll in a therapy with abuse or dependency diagnoses documented in their medical and/or mental health histories. As reported by participants, additional identifying features of these older adults in question were noted in highest frequency as follows: low socioeconomic status, serious co-occurring medical conditions, physical disabilities or limitations on mobility, co-occurring mental illness, and familial as well as social isolation. The interviewed clinicians unanimously imparted, "…the older adults currently in treatment are living on fixed incomes," and more often than not, independently from family or community and social supports or outlets. In correlation, seven of the twelve clinicians interviewed made note that the older adults whom they treat in therapy consistently present with co-occurring depression and/or mood disorders.

As one participant explained, "…older adults will often come into my office with the presenting concern of a persistent physical ailment for which they can find no cure…as I carry on in further assessment of the issue, nine times out of ten the physical pain is amplified through a somatization of unprocessed emotive material that they find unbearable to address. This avoidance and repression is generally managed or masked by substance misuse." Over half of the participants surveyed in this research reported a similar response, and additionally noted that they've seen a rise in the amount of prescription pain killers (opioids) prescribed to this older adult population.

Assessment and Screening

As the research participants continued to quantify the characteristics of the older adult populations they serve, the interview protocol organically led them to expand upon how they approach an assessment of these characteristics – both initially, within the first session, and ongoing, as the treatment evolves. Interviewees unanimously reported that they employ a standardized tool of initial assessment with all clients in their caseload. None of the clinicians specified any alteration or modification in this protocol when approaching the initial assessment of older adult patients.

Both research participants practicing within agencies described how their rubric for initial assessment was mandated as a template in their note-taking systems. Neither clinician chose to expand upon the evidenced-based questionnaires housed within said templates. The remaining ten privately practicing clinicians gave extensive explanations as for the origins of their employed assessment tools. Most clinicians in private practice explained how their initial assessments are based from a rubric compiled through collegial collaborations, and personal preferences rooted in clinical experiences throughout their years of practice. As one clinician

explained, "…the PHQ [personal history questionnaire] I initially request my patients complete is a conglomeration of evidenced-based questionnaires and a series of questions I've found to produce the most robust answers – the kind of answers that help me really get to know about all aspects of a person."

Overall, the ten respondents in private practice noted application of the following evidenced-based assessment tools in decreasing order of frequency: AUDIT-C, AUDIT, CAGE-AID, MAST-G, DAST-10, SASSI, and the BACH. Clinicians omitted reference to personal preference in application of one assessment tool over the other as it applies to alcohol and/or substance misuse. However, these ten research participants were unanimously eager to share the type of presentation they often observe in older adult patients as a result of the before mentioned assessments. Eight of the ten clinicians in private practice made it explicitly clear that they have come to see opioid and alcohol misuse in the highest propensity when treating adults 55+ (as opposed to any other substances). Half of these clinicians referenced an observation of increased desire for a feeling of sedation in the older adults they serve. As one of these clinicians explained, "…I treat a mixed composition of older adults who have documented histories of substance misuse or not…even those with a history of amphetamine abuse [cocaine, crack cocaine, etc.] seem to be drawn to the sedative effects of opioids in older age." Among this group of respondents, the prescription drugs mentioned in highest frequency for misuse, dependency, or abuse within the older adult populations were benzodiazepines, Xanax, Vicodin, and Klonopin. These clinicians responded without any demarcation of the gender identities of older adult patients correlated in highest propensity to misuse of these substances. However, as these respondents began to shift focus to an identification and depiction of alcohol misuse among the populations of older adults they serve, the identified male patients were consistently

underscored as struggling the most. Each of the twelve research participants emphasized the grave difficulty they find in supporting these older adults' motivation to changing established drinking behaviors (as they are often long-standing habits). Although withdrawal symptoms become a compounding factor for these mental health professionals while treating older adults, it is further expanded upon in these findings as to how clinicians continue to forge on in their collaborative approach to enduring assessment and treatment of such a diagnostic impression in the patients with whom they clinically consult.

Treatment Approaches

Interviewees unanimously acknowledged that their treatment approach varies uniquely with the individuals whom they therapeutically meet. Still, with this understanding at the forefront of the mind, there were definite themes that emerged in response to the questions asked in the research protocol regarding treatment modalities and overall clinical approach. Each respondents' clinical orientation and perspective aside, all reported that a secure sense of available consultation and trans-disciplinary collaboration amongst all providers interfacing with the older adult patient in question was the top ingredient for successful treatment of substance misuse following initial detection. Those clinicians who worked in a setting that fostered this collaborative approach reported a greater sense of confidence in both assessment and treatment of older adults on their caseloads. The treatment frameworks and perspectives that were most frequently used among the group surveyed included cognitive behavioral modalities, alcoholics anonymous or narcotics anonymous referrals, and motivational interviewing techniques. Three of the twelve participants surveyed in this research made comment that they "…feel at a loss," and somewhat hopeless in approaching this type of treatment with older adults who have yet to seek out clinical services for substance misuse and related struggles in their lives. One of the

three explained, "…motivational interviewing tactics can only go so far…I honestly wonder of what use it is to approach such a late onset shift in life with clients sometimes."

Summary

As outlined in the above findings, the questionnaire protocol elicited participating clinicians to identify areas of current best practice, as well as areas of assessment and treatment in need of standardization and implementation improvement. Respondents first positioned themselves within the social service stratosphere, and then willingly reported on their daily practices in the therapeutic consultation of older adults. Although some of the responses were flavored with a tone of hopelessness and frustration, there were comparable responses from clinicians exemplifying eagerness and excitement for the onset of shifting clinical approach to the assessment and treatment of those older adults struggling with alcohol and substance misuse concerns. These reviewed findings will serve as a solid framework for further research oriented and clinical discussion, both in the subsequent chapter and additional research necessary in the field of social work.

CHAPTER V

DISCUSSION

The objective of this qualitative study was to explore the attitudes and perspectives employed in the assessment and treatment of older adults struggling with alcohol and substance misuse issues in the New York City Metropolitan area. Some of the clinical dynamics and practices discussed by participants were aligned with the review of literature, while additional methods and experiences were expanded upon throughout the interview and information – gathering process.

Throughout the methodological collection, organization, and analysis of qualitative responses, it became apparent that the twelve participating clinicians found some commonality in approach and treatment perspective with the older adult populations in question. However, this overlap in approach was also identified with discontent in assessment of overall standardization of clinical practice in preventative assessment and treatment. This final chapter discusses the previously identified findings as follows: Key Findings, describing the relationship between the study results and previous literature; Implications for Social Work Practice, discussing how clinicians can incorporate the findings from this study in their daily practice, while additionally exploring the importance of these assessment perspectives on the broader mental health and medical fields; and finally, Recommendations for Future Research in the field of geriatrics, expanding upon the limitations and biases of this study as a whole.

Key Findings

The literature suggests that the largest aging cohort in America is the “baby boomers” (SAMSHA, 2011; Jeste, & Patterson, 1999) – With their mark of the 1960s forever etched in the walls of this country’s history, coupled with the many facets of the aging process [loss and

bereavement, retirement, onset of a new caregiving role, etc.] it's no wonder participants in this study repeatedly made note of how imperative preventative assessment and treatment of older adults struggling with alcohol and substance misuse issues is. This exploratory study sought to interview clinicians as a way to explore the answers to the questions: Do you [clinicians] assess for alcohol and substance misuse in the older adult patients you treat? What are the clinically mediating factors within this assessment and treatment process? Over half of the respondents aligned with the research of Shibusawa (2006) in reporting that preventative detection or assessment can be difficult when working with the older adult populations.

With the risk factors for alcohol and substance misuse outlined (Brennan, Moos B., Moos R., & Schutt, 2010; Shibusawa, 2006; Widlitz & Marin, 2002) and named – depression, anxiety, loss and bereavement, social isolation, chronic pain, loss of physical mobility, loss of partner or employment, retirement, etc. – the field of mental health is called to advance in standardization of assessment and treatment of those older patients struggling with alcohol and substance misuse. Although competency in unique and individual technique was reported amongst the majority of research participants, a call for standardization and advancement of preventative procedures was unanimously announced. The National Survey on Drug Use and Health (2009) projects that in 2020, *non-medical use* of psychotherapeutic drugs among baby boomers will increase from 1.2% (911,000) to 2.4% (2.7 million), and additional research points to a transition from alcohol to benzodiazepine misuse and/or abuse in older adult populations prescribed such medications in higher propensity (Bergkvist, Eriksson, Hoglund, Larsson & Midlov, 2009) – we must act with haste in our ethical commitment to the advance of practice and research *now*!

The pool of twelve clinicians interviewed for this study produced some interesting speculation as to why the preventative assessment and screening techniques available are under

employed or utilized in a fashion most useful to this clinical provision. Even those respondents who were not substance abuse practitioners or credentialed in any sort of substance abuse framework mentioned how, "…I would imagine that if substance abuse treatment was my specialty, or I was more well versed, I'd be more comfortable in asking older adults direct questions on the issue…I'd be trained on how to." As paralleled in the literature, those healthcare providers who practice with a perspective and lens for distal or societal aging (society's expectations of how people should act as they grow older; ie. depression and anxiety are simply "normal" aspects of aging), can deter initial screening or further assessment and treatment of those patients who need it most (Mcinnes & Powell, 1992; Oslin, 2006; De Grey, 2007; Marin & Widlitz, 2002). Those clinicians who might be in isolation from outside consultation or supervision would not have the opportunity for reflection on these dynamics of projected societal influences of ageism.

Furthermore, the respondents pointed to a need for additional standardization in social work education overall. Clinical comfort in the assessment of alcohol and substance misuse in older adults will soon be imperative to the work of *every* mental health service provider – not only those with alcohol and substance misuse credentials. A unanimous response from those interviewees holding credentials as alcohol and substance misuse practitioners was a general tone of frustration in reference to any "success" in treatment of older adults consulting for alcohol and/or substance misuse concerns. Existing literature outlines somewhat the contrary, that instead, once older adults are in a therapeutic treatment setting they have better outcomes than younger adults (Benza, Calvert, McQuown, 2010; Bernabei, Gambassi, Landi, Mor, Sgadari, & Zuccala et al. 1998). Only further research in this area will prove to expand upon these findings.

Implications for Social Work Practice

The twelve New York State licensed clinicians interviewed for the outlined purposes of this research, have comprised a purposive sample pool with reflective attitudes and treatment perspectives readily valuable to the much needed ongoing research in the field of mental health for older adult populations. The practices of clinicians in this randomized sample are in no way generalizable beyond the New York City Metropolitan area, but the outcome analysis of the narrative responses should prove useful to the scientific research published on the topic – efforts channeled towards hypothesis generation is intended.

Many of those clinicians credentialed as substance abuse practitioners and interviewed for the purposes of this research, noted a shift in perspective as it came to assessing older adults for substance use issues, following their specialty training. These same clinicians also reflected on the fact that they must persistently be aware of their projected societal norms when consulting with older adults. As one of the respondents identified, "…in working with patients in a therapeutic dyad, we bring our own personal narratives as well as societies influences into the consulting room – it really takes a conscious effort on my part [as the therapist] to keep the idealization I hold for my Grandma…out of the room." As clinicians engage in treatment with older adults, regardless of their projected social narratives, they must balance an awareness and filter of this fact along with a bare attention towards thorough, unbiased assessment and treatment. As a majority of the participants in this study explained, the process of achieving this state in daily practice requires the trans-disciplinary support of the entire treatment team engaged with the older adult, in addition to ongoing supervision and outside consultation available to the therapist. This research analysis has hopefully brought attention to a greater need for such clinical supports, collaborative reflections, and teamwork. The implications of these findings are

far-reaching for those mental health clinicians working within settings where this type of collaboration is ill-advanced

Additional implications for the field of social work are rooted in the diversity of approach reported as a mediating factor when working with the older adult populations. Since methods of exploring substance use in the older adult populations vary in conceptualization and implementation per clinician (especially exemplified by the 10 out of 12 privately practicing clinicians interviewed for this study), clinicians should also pay close attention to ways in which practices should be tailored to meet the cultural, religious, and personal aspects of the clients. It was unanimously noted amongst the interview cohort, that the fields of medical and mental health alike must take steps towards the advancement of assessment and treatment protocol for alcohol and substance misuse in all populations, however, *especially* utilized in a preventative manner with respect to the ever-growing older adult populations.

Recommendations for Future Research

In addition to the above noted implications and recommendations for future research, the twelve clinicians interviewed for this study generated a series of commentary that leaves plenty of space for ongoing scientific inquiry. As noted throughout this research analysis, the perspective of the clinician is one least captured throughout the literature. However, as has been exemplified here, the perspective of the clinician can be of great use in working towards refinement and standardization of assessment and treatment protocol within the field of mental health. The most amplified finding of this research is that the field of mental health is lacking in its ability to preventively assess and treat older adults struggling with alcohol and or substance misuse. Researchers in the New York Metropolitan area can be on the forefront of this discovery and program implementation.

However, a standardization of protocol is not introduced after the analysis of single data sets such as this one. Each study presents with its own share of limitations and biases, but filtering these based on the recommendations of standing research is the process of ethical scientific inquiry. The limits to this sample pool are constricted with respects to employment of clinical practice [10 of 12 interviewed are in private practice], location of practice [all interviewees practicing within three of the five boroughs of New York City], and biased as it comes to the populations they treat [work with older adults was part of inclusion criteria]. Comparisons of responders and non-responders was not possible, thus, it is conceivable that those who volunteered for the study were systematically different with respect to an interest in working with older adults who struggle with alcohol and substance misuse issues in the New York City area.

As the reliability of measurement and validity must also be considered, future research should strive to remove the multitudes of bias presented in the interview protocol and subsequent data analysis. In using an interview of open-ended questions, anonymity for the informant was not possible. In order to contact the participant and verify their licensure status, their identity was known. For the purposes of this graduate level study, the most unbiased assurance of confidentiality, reliability, and validity was not possible. Ongoing research within the frame of this topic should begin to focus on the collection of more qualitative and quantitative data as a whole. Mental health professionals should not fear what is unknown, but rather observe and record these findings for the purposes of consultation and additional ongoing analyses.

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Appendix A.1

Recruitment Email

Subject line: I want to get your perspective – Screening techniques

Do you work with older adults? Do they present with concerns of substance misuse and dependency? Do you consider an ongoing assessment for substance use with *all* of the older adults which you currently work? I would like to invite your participation in my research study, centering on clinician's approaches to the assessment of alcohol and substance misuse in the populations of older adults that we serve.

My name is Erin Conlan, and I am recruiting clinicians currently consulting with older adults on their caseloads, in the New York City Metropolitan area. The purpose of my proposed research is to explore case manager's use of advanced screening and assessment techniques for substance abuse and/or misuse with older adults.

Specifically, I am interested to learn more about how it is that case managers perceive the use of substance abuse screening with older adult clients (55+); and, furthermore, how they utilize and understand substance abuse screening and assessment practices with older adults.

If you have been practicing with a license for at least a year, and do ***not*** hold a certificate of advanced practice as a geriatric care manager – your participation is a necessity for the advancement of our field of clinical practice! I am conducting this research for the purposes of my MSW thesis project, and would greatly appreciate any and all interest. I would also encourage you to pass this along to any other clinicians you know in the area. All participation will be voluntary, and I am happy to answer any further questions regarding this research prior to commitment. Please see attached PDF file for additional information.

Dates: Email or call with your availability

Times: (30 minutes)

Topic: Screening Techniques: Clinicians' Views and Approaches to Assessing Alcohol and Substance Use in Older Adults

Contact: Erin Conlan
xxxxxxxxxxxxx
EConlan@smith.edu

Appendix A.2

Appendix B

Interview Protocol

**Please remember not to use names or any identifying information when talking about the individuals you have worked with.

1.) Name:_____

2.) Race:_____

3.) Ethnicity:_____

4.) Sexual identity:_____

5.) Gender identity:_____

6.) Years of practice:_____

7.) Agency affiliation and position:_____

8.) Agency location/setting:_____

9.) Please provide a brief description of your professional training in relationship to the population you serve (Courses taken, certifications, licensures, work beyond the graduation level, research, etc.):
_____
_____
_____
_____

10.) How are clients referred to your practice setting?
_____
_____
_____

11.) Please provide a narrative description of your caseload (Number of clients, major identifiers – age, gender, class, race, ethnicity, immigration status, sexual orientation, disabilities, religion, employment and finances – anything relevant to your work.):
_____
_____
_____
_____

12.) What does substance use look like in older adults? How often does it show up? What forms has it taken in your work?

13.) What does alcohol use look like in the populations of older adults whom you consult? How often does it show up? What forms has it taken in your work?

14.) Does your agency have a protocol as for how to approach the issue with this population?

- If so, what screening tool is used?
- How effective do you find this screening tool to be?

15.) What is your personal approach to screening for alcohol and substance use/misuse when working with older adults?

16.) How does this process look as you continue working with a particular client?

17.) When detected, which treatment modalities do you utilize most?

18.) What is the clients' response to these treatments?

19.) Please identify areas of this process that you see as needing improvement.

APPENDIX C

INFORMED CONSENT

Screening Techniques: Clinicians' Views and Approaches to Assessing Alcohol and Substance Use in Older Adults

Dear participant:

My name is Erin Conlan, and I am currently studying for my master degree in the field of social work at Smith College. I am recruiting participants for the purposes of a research project and thesis, as my final year in the program winds down. As stated above, my research hopes to look at the views of clinicians and the approaches they employ in assessment of alcohol and substance in the populations of older adults whom they serve. I hope to further bolster the research in the field of substance use assessment, most specifically by providing data involving clinicians' attitudes and practices employed in the assessment of older adults; all with the possibility of creating a new standardized assessment tool. As I plan to recruit clinicians practicing for at least a year – *licensed;* who works with a population of older adults (55+), and do ***NOT*** hold an advanced certificate training as a geriatric case/care manager – my MSW thesis, dissertation, possible publications, and presentation will be applicable to our practices and growing field of research.

Potential participants for interviews will first be asked to read and sign this form of consent. Participants who agree to be a part of the study will be asked to participate in a single, audio-taped interview. Each telephonic interview will last approximately 30 minutes. Each participant will additionally be given the opportunity to be placed in a drawing for a $25 Barnes & Noble bookstore gift certificate following completion of all interviews. Participants will be asked to provide some demographic and background information, and then further discuss their substance abuse screening and assessment practices with older adults. The primary researcher has designed an interview protocol for the proposed study that will serve as a guide in conducting interviews. Participants will be asked to openly discuss their techniques and practices utilized when screening their clients for substance abuse/misuse behavior upon initial, and throughout ongoing assessment. Participants will be asked to share their perception, attitude towards, and definition of substance abuse/misuse in the populations of older adults they serve.

Each participant will be asked to sign this form giving permissions for their voices to be recorded and participate in the interview. Each interview will be held in the outmost confidential manner, only the primary researcher will be aware of participants' identities.

It is anticipated that there is no greater than minimal risk for participation. All identifying information will be held in confidence. This exploratory study could enhance our understandings regarding clinicians' perceptions of roles and activities in this increasingly important area of practice. A new way to evaluate and care for these older clients could then emerge and bolster a stronger set of preventative measures in the field of social work – a new screening tool could be devised as a result of the knowledge and techniques explored.

All consent forms collected will be placed separately from audio tapes of the sessions, locked in a private confidential cabinet along with all flash drives containing any electronic data which includes code numbers. Additionally, participants will be reminded not to use names or any identifying information when talking about people they have worked with. As I am the principle researcher (and sole transcriber) I will be the only person privy to the connection of name and voice of each participant. Confidentiality will be upheld throughout the production of results. Names and code numbers will be omitted from the final thesis write-up, as well as future presentations and publications of the data. I will either speak of the participants as a group when I compile the results, or identify them as "One participant…another participant." In addition, it should be noted that my research advisor will be the only additional person (aside from myself) that will have access to the raw data, only after identifying information has been removed. All data and tapes resulting from the interviews will be kept in a secure place for three years as required by Federal regulation. After that time they will be destroyed or continue to be kept secured as long as the tapes and data are needed for this research project. When no longer needed, the data will be destroyed.

The nature of your involvement with this interview is completely voluntary. You may withdraw at any point. You may refuse to answer any questions at any point and your withdrawal will be discussed in the representation of data in a confidential manner. My contact information is listed below. Should you have any concerns about your rights or about any aspect of the study, I encourage you to contact me or the Chair of the Smith College School for Social Work Human Subjects Review Committee at (413) 585-7974.

YOUR SIGNATURE INDICATES THAT YOU HAVE READ AND UNDERSTAND THE ABOVE INFORMATION AND THAT YOU HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS ABOUT THE STUDY, YOUR PARTICIPATION, AND YOUR RIGHTS AND THAT YOU AGREE TO PARTICIPATE IN THE STUDY.

_____

Participant signature Date

_____

Researcher signature Date

Feel free to contact me at any point in the future with any questions or concerns regarding your involvement in this study – Thanks for your participation and contributions!

Erin M. Conlan
2460 29th Street
Astoria, NY 11102
EConlan@smith.edu
(518) 258-8932

**Please keep a copy of this form for your personal records.

Appendix D

Demographic Characteristics of the Clinician

Table

Demographic Characteristics of the Clinician

		Hetero. n=6 No response n=2	Gay n=2	Lesbian n=2	Total n=12
Race		Male		Female	
	Black		2	--	
	White		1	6	
	Hispanic		--	1	
	African American		1	1	
Ethnicity					
	Caucasian		--	2	
	Black		1	1	
	Irish		--	2	
	Italian		--	1	
	Indian		--	1	
	N. European		1	--	
	Guatemalan		--	1	
	African American		1	--	
	Dominican		1	--	
Agency location					
	Queens		2	3	
	Manhattan		2	2	
	Brooklyn		--	3	
	Bronx		--	--	
	Staten Island		--	--	