Addictions and the Older Person

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Vancouver, July 4, 2001

Profile of the

Older Person

with a

Substance Use Problem

Behavioral Indicators

- Multiple med use
- Expired med use
- Med + alcohol
- Excessive drinking, perfume, mints
- Extreme emotional reactions
- Thinking difficulties (confused, forgetful)
- MD/pharm shopping
- Defensive
- *Nests* in chair
- Neglects home/bills
- Appears depressed
- Erratic sleep
- Social withdrawal
- Impaired coordination

Verbally Indicates:

- Has substance use problems
- Vague health problems (headaches) or avoids discussing
- Loss of sex drive
- Memory lapses, blackouts
- Light & sound sensitive
- Loneliness, helplessness
- Family hx of drug problems
- Abuse hx
- Persistent financial difficulties

Physical Appearance

- Poor hygiene
- Bruising, especially at furniture height
- Alcohol odor in air, on breath, clothes
- Weight gain or loss
- Slurred speech
- Broken blood vessels on face
- Fatigue, leg cramps
- Chronic gastric problems
- *Flu* symptoms
- Skin changes
- Blackouts,edema
- Tremors, impotence
- Yellow or bloodshot eyes

Signs of Aging or a Misuse Problem?

- Confusion
- Depression
- disorientation
- Unsteady gait/falls
- Recent memory loss
- Loss of interest in activities
- Social isolation
- Tremors
- Irregular heart rate
- Poor appetite
- Stomach complaints
- Decreased cognitive function

Early Onset

- Same or decreased use
- Consequences of long-term use most visible

Late Onset

- Increased use
- Reason for use most visible (crisis)

Similarities

- Both consuming in response to negative feelings of loss, loneliness, isolation, boredom
- Consuming alone
- Poor self-esteem related to consumption pattern

Factors Contributing to Substance Misuse

EARLY ONSET

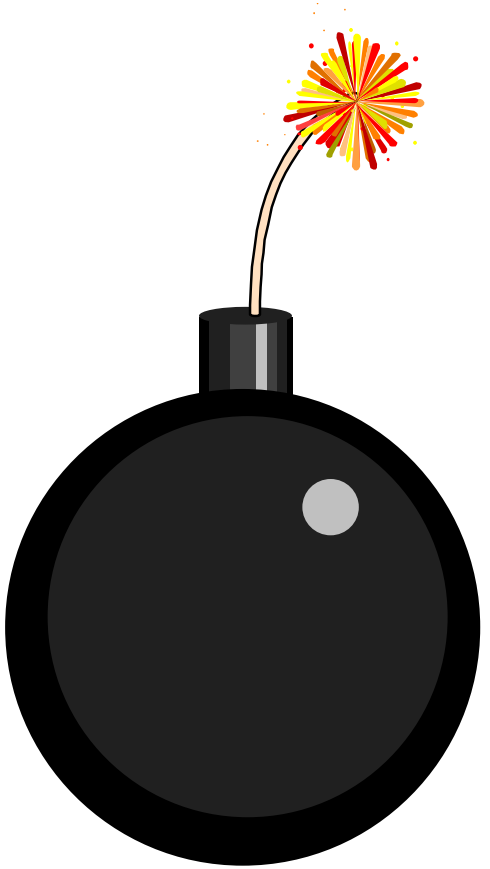
- living alone
- supports gone
- poor communication with family
- environment
- malnourished
- physical complications

LATE ONSET

- peak at 65-74, reacting to stressors of aging
  - leisure activities
  - acute depression in bereavement
  - declining physical health
  - decreased tolerance

Dear Lord, if the world is so overcrowded, why doesn't anyone come to visit me?

Why are medications and older persons of special concern?



Medications can be a problem for older adults because:

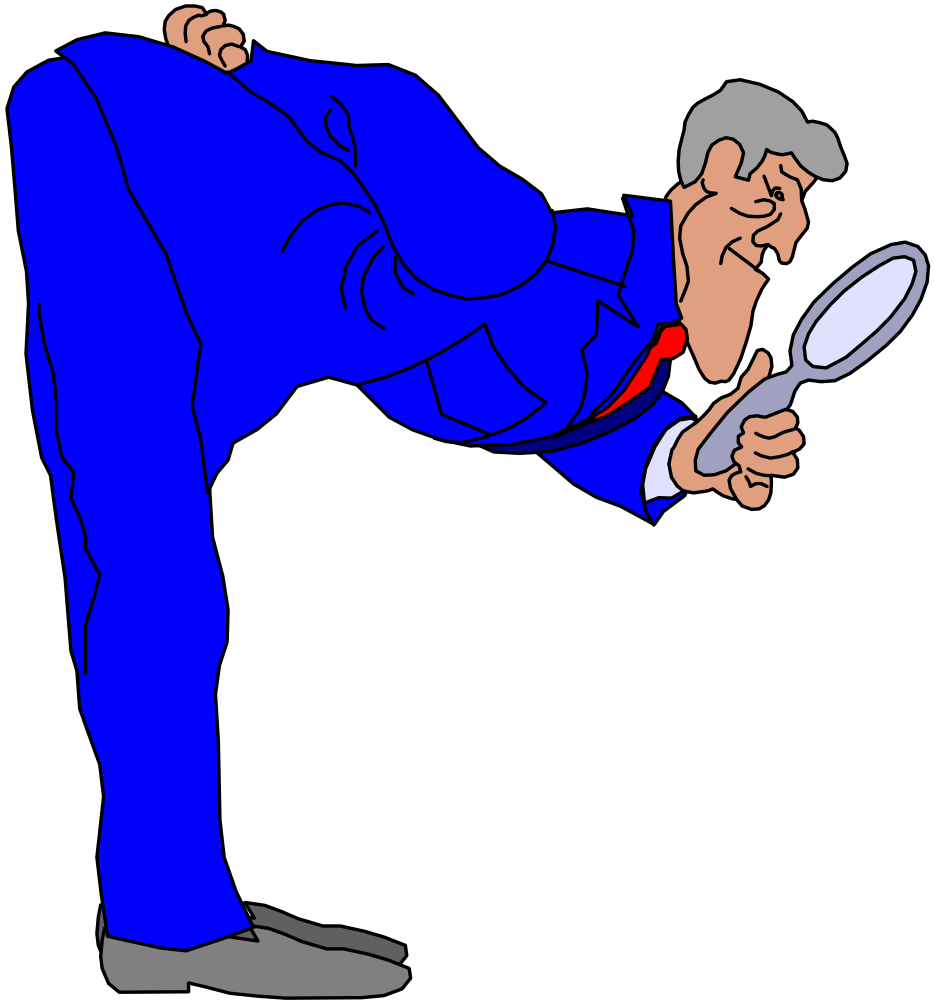
- Longer effects & side effect (due to changes in metabolism)
- Seniors are more sensitive to effects & side effects
- As we age, we are more likely to be prescribed medications (40% of medications used by those 65+, or 12 % of population)

Side Effects

- Unsteady walking
- Dizziness
- Daytime sleepiness
- Memory loss
- Falling
- Sleep difficulties
- Confusion
- Poor coordination
- Slurred speech
- Addiction

Who Identifies a Problem?

- Home caregivers
  - visiting service providers
  - staff of seniors housing
  - volunteers
- Family
- Hospital
  - emergency



Common Themes of Treatment Programs for Older Persons

Common Themes of Tx Programs for Older Persons

- Assertive case finding and outreach
- Optimal medical care
- Resolution of ADL problems
- Counseling/practical problem solving
- No insistence on total abstinence
- Use of leisure time addressed
- Improved socializing skills

Effective Strategies for Older Adults (as per Setting the Course)

- Individualized approach which does not require abstinence, focusing on health enhancement & harm reduction
- Outreach
- Flexibility, offering services in home or community environment
- Acknowledge & support grieving needs

Effective Strategies for Older Adults (as per Setting the Course)

- Address underlying problems: chronic illness, loneliness, isolation, depression and loss of meaning of life
- Encourage group activity (peer support and reduce isolation)

Effective Strategies

- Support late-life issues (mortality, self-esteem)
- Be knowledgeable about and refer to other appropriate health/social services

Ontario Ministry Documents Referring to Older Adults As a "Special Target Population"

- Graham Report (1988)
- Putting People First
- Treating Alcohol and Drug Problems in Ontario: A Vision for the 90's ('Martin Report' 1990)
- LTC/MH Interface document (1995) - PIECES Training (1998)
- Rationalization Project - Guidelines for Restructuring Services (OSAB 1996)
- Making It Happen (1998)
- Setting the Course (OSAB 1999)

Helping Older Persons Change

- Health Professional
  - attitudes and knowledge
  - understanding
  - skills
- Older person
- External factors

Staff Qualifications

- Gerontology knowledge
- community work
- communication skills

Needed Staff Qualifications

- Comfort with pre-contemplative client
- Skill in moving them to contemplative
- Acceptance if there is never movement
- Skill at advocating for more responsiveness in other sectors
- Demonstrated skill at being a resource to other services & sectors (often a condition of referrals)

Role of Health Professional

- Developing a trusting, non-judgmental relationship
- managing crises such as inebriation, the D.T.'s, violations of 'Community Rules'
- assessing the client's substance use situation

Role of Health Professional

- Developing and implementing a care plan based on the concerns, strengths, vulnerabilities and priorities of the resident
- Advocating on the resident's behalf
- Evaluating success with the resident according to what is meaningful to him

Facilitating Change

- Establish rapport / relationship ???
- Describe what you see
- Generalize
- Offer support through listening and understanding

Assessment

- In-home allows for observation
- Identify strengths
- Identify concerns
  - medical
  - financial
  - accommodation
- Comprehensive
  - health concerns & priorities
  - ADL supports
  - relationships
  - recreation & leisure activities
  - spiritual beliefs & practices
  - ?? substance use
  - physical, emotional, mental health condition??

Substance use history

- Assume the substance (i.e. alcohol) is used; normalize; be non-judgmental
- Determine consumption hx, pattern, abstinence and their meanings
- Use their terms and value system
- Ask for clarification if discrepancies

Treatment Goal = Improved Health & Quality of Life

- Identify strengths, interests, concerns and priorities
- Respond to violations of Community Rules
  - do not demean, chastise, shame
  - ask resident for ways that you can assist resident in complying with rules
  - make recommendations as to how rules can be complied with, alternatives, prevention, harm reduction

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- Demonstrate respect, regardless of state of sobriety
- Document your interactions
  - to increase consistent team approach & support for resident
  - to evaluate change

Length of Time for Change to Occur

- ? many months
- skill and comfort in working in pre-contemplative stage
- team approach, consistency

Evaluation

- Should directly reflect the goals established
- I.e. if goal is for reintegration into community, then evaluation should reflect that
- if goal is to reduce risk of homelessness, then evaluation should reflect this

Responding to Gaps

- Support for caregivers
- Vulnerability / elder abuse
- Acquired brain injuries
- Substance-induced falls
- Gambling
- Home detoxification - complemented by treatment . . .

…Responding to Gaps

- Clinical consultations
  - Toronto Rehabilitation Institute
  - Sunnybrook-Women's College
- Program Development Consultation
  - London, Ontario for 6 western Ontario addiction treatment programs
- Policy Consultation
  - health care restructuring
  - Ontario Works, CTO . . .

…Responding to Gaps

- Best Practices Development
  - Provincial (I.e. ‘Setting the Course’)
  - Federal (‘Seeking Solutions’)
- Innovative Partnerships
  - housing, long term care, shelters,

Summary

- There is an unmet, until recently, unrecognized need
- The need is far greater than the resources to address it
- Need will clearly grow (38% in 20 years)
- ’Best practice' models suggest case finding, outreach, harm reduction, gerontology and mental health expertise

For More Information, Contact...

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