Addictions Treatment for Older Adults

Evaluation of an Innovative Client-Centered Approach

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ABOUT THE AUTHORS

Kathryn Graham, PhD, is a scientist with the Addiction Research Foundation in London, Ontario, Canada. Over the past ten years, her research has involved evaluation of addictions treatment programs and systems with special focus on treatment of older adults, case management, and relapse prevention. She has published on these topics as well as on topics pertaining to evaluation methods. Her current research includes an evaluation of a community intervention to prevent and treat problems related to use of alcohol and prescription drugs by older adults and a line of research examining the social factors related to alcohol use and problems.

Sarah J. Saunders, MD, founder of the Community Older Persons Alcohol Program (COPA), is currently retired from the Addiction Research Foundation. While there, she was involved in the development of one of the first community outreach assessment and referral services in Ontario. As a staff physician, she worked in various capacities, including lecturing at the University of Toronto. During the past twenty years, Dr. Saunders has played a major role in education, program development, and research in the area of alcohol and drug use and misuse by older adults.

Margaret C. Flower, RN, has ten years of front line experience in addictions counseling and health education, working with government, hospitals, and social services. Currently, she is an assessment worker with Metro Addiction Assessment Referral Service in Toronto. She has presented workshops and seminars to health care professionals and published on substance abuse and the elderly.

Carol Birchmore Timney, MA, is Research Associate with the Addiction Research Foundation. She has been involved in research in the area of case management in the addictions treatment system and the impact of substance abuse on the family.

Marilyn White-Campbell, DGrt, is a consultant gerontologist and a primary care outreach worker with COPA. She has made many

invited presentations on working with older people who have substance-related problems and on issues related to elder abuse. She has also been involved in several research projects relating to alcohol and drug use by older people.

Anne Zeidman Pietropaolo, BSW, BEd, completed a clinical internship at COPA and played a major role in the case study research conducted as part of the COPA evaluation. She is a teacher at the George Syme Community School in Toronto and a member of the City of York Board of Education.

Preface

This book describes the results of evaluation research conducted over several years at the Community Older Persons Alcohol (COPA) program. COPA is a program specifically designed for older adults who are experiencing problems related to the use of alcohol or other drugs. A variety of evaluation approaches were adopted since the program differed greatly from traditional addictions programs and the clients reflected a population usually not served by addictions treatment programs.

The program philosophy is that counselors can help people reduce substance abuse and improve other areas of their lives by allowing each person to determine his or her own treatment needs. Moreover, the program is unlike other addictions treatment programs in that clients of the program are not required to admit that they have an alcohol or drug problem in order to receive help. Although the treatment process typically includes counseling and education regarding the relationship between specific life problems and consumption of alcohol and drugs, the overall focus is holistic and driven by the needs of the client. The range of interventions is broad, often involving counseling in the person's home, accompanying the client to important appointments, and advocacy and coordination with other services and with the clients' family on behalf of the clients. A full description of the program and its rationale is provided in Chapters 1 and 2.

Evaluation of the COPA approach required considerable deviation from classical pre-test/post-test evaluation designs. In particular, the lack of a requirement for clients to admit to alcohol and drug problems presented unusual difficulties for evaluation. For many clients, a valid assessment of pre-treatment functioning only emerged as the client and counselor developed rapport over the course of the treatment process. Thus, since valid information only emerged through the treatment process, usual evaluation methods, such as using a

no-treatment control group, were not possible. Therefore, assessing the extent that clients improved during treatment involved the use of several convergent methods of data collection. The flexible individualized approach to treatment also posed problems for evaluation. Again, the approach was to draw conclusions from the convergence of several methods. One method used to better understand the clients and the treatment process was the case study. Thirty-six studies were completed. There are presented in Chapter 3 to provide an overall sense of the nature of the clients, the program, and the recovery process. The methodological approach to the more quantitative aspects of the evaluation is described in Chapter 4.

The remainder of the book focuses on the findings of the evaluation. Chapters 5, 6, and 7 describe the characteristics of COPA clients and relate these findings to what is currently reported in the scientific literature about older substance abusers. Chapters 8, 9, and 10 describe how outcomes were measured, overall outcomes of the COPA program, and predictors of outcome. Again, these results are discussed in terms of the existing literature and the general implications of the findings. The final chapter (Chapter 11) summarizes the major findings and conclusions of the COPA evaluation.

Acknowledgements

Evaluation of the Community Older Persons Alcohol (COPA) Program took place over a number of years and benefited from contributions by many people. We cannot list everyone who contributed in some way, but would like to take this opportunity to express our appreciation to some of the major participants in the project.

During the early part of the project, Jim Shea was a counselor at COPA. Besides providing data from his client contacts, he also contributed his wisdom to refining the data collection methods. Jadzia Romaniec became part of the COPA study as an observer in our initial attempts to assess inter-rater reliability of the data we were collecting. Her suggestions improved the process and her observations helped us to find ways to keep the project on track. During most of this study, the administration of the project was done by Helen Carvalho. As secretary at COPA, she made clients feel comfortable, handled numerous crises on the telephone, and generally managed the heavy administrative burden of the evaluation. This included making sure the counselors completed their paperwork and organizing information to be sent to the researchers. She left COPA to work full-time on her Bachelor of Science degree.

Susan Miklejohn from the Community Occupational Therapists Association (COTA) was generous with her time in the early stages of the project. She was very helpful in refining the treatment approach. Queen Elizabeth Hospital (Toronto, Ontario) provided space and other types of support. Throughout the project, we received consistent support from the COPA Board and from the Addiction Research Foundation (ARF). In particular, this project could not have done without the support of Mario Faveri of the ARF. Cindy Smythe of the ARF read numerous drafts of this and other reports about COPA and provided helpful suggestions. Pamela Brett also provided helpful comments. Dr. Bruce Carruth (Series Editor)

provided useful suggestions for improving this book, as did the technical editors at The Haworth Press. Barb Keogan, Sue Steinback, Wendy Rush, and Cindy Reid were able to meet high demands on their word processing expertise, both in the preparation of this book and in the production of compact data collection forms.

Also, a number of colleagues in the fields of addictions and gerontology took the time to provide helpful feedback on the typology of older alcohol abusers developed from the case studies (Chapter 3).

Finally, the most important contributors to acknowledge are the clients of COPA. Because the study was unobtrusive, most clients did not know they were contributing to research. Nevertheless, they were the ones who taught us about the subject of "alcohol and the elderly" and showed the counselors the kind of help that was needed and wanted. We are especially grateful to the clients who allowed an observer into their homes so that we could assess the reliability of the data we were collecting. The clients, their stories, and their spirit made the evaluation challenging (at times frustrating!) but, most of the time, a lot of fun.

Chapter 1

The Need for Addictions Treatment for the Elderly

Only in the past decade have the special needs of older persons who have alcohol or drug problems been given much consideration. This lack of attention to substance problems of older persons was partially attributable to the low problem rate estimated for this group on the basis of general population surveys. National surveys in the U.S. and Canada have indicated that older persons report the lowest rate of alcohol problems and the highest rate of abstinence compared to other adult age groups (Clark & Midanik, 1982; Health and Welfare Canada, 1990). In addition, illicit drug use is exceedingly rare among older adults (Health and Welfare Canada, 1990). Moreover, surveys of treatment programs have found that older persons are underrepresented in treatment populations (Rush & Tyas, 1990).

Nevertheless, substance use and abuse by older people has begun to receive more attention. This has occurred for several reasons. First, problem rates based on community surveys may underestimate the extent of the problem, since surveys usually exclude institutionalized elderly where problem rates seem to be higher (see review by Gomberg, 1982). Second, problem rates may be inaccurate because the framework for defining alcohol problems has tended to be based on the problems experienced by younger people (e.g., family problems, employment problems) rather than those types of problems more likely to be experienced by older alcohol abusers, such as inability to care for self and home, and memory or cognitive problems (Graham, 1986).

Third, it is well recognized that the human body's ability to absorb and eliminate alcohol and drugs deteriorates with aging.

Therefore, older persons may be more likely to experience problems from levels of alcohol use that typically would not cause problems for younger persons. Fourth, prescription drug use (including use of psychoactive prescription drugs) is highest among older people (Health and Welfare Canada, 1990). Prescription drugs may directly cause problems for the user (e.g., problem consequences, addiction), or these drugs may interact with alcohol, accentuating any effects of drinking. Finally, as will be described in Chapter 2, clinical primary care workers (e.g., physicians, public health nurses) began to express a need for strategies for dealing with older people experiencing alcohol and drug problems. Thus, despite the low prevalence rates indicated by general population surveys and surveys of treatment programs, greater attention began to be paid to the problem because of cases being encountered by families of older persons and by health and other professionals interacting with older persons.

The overall conclusion of recent literature reviews (Schonfeld & Dupree, 1990) is that alcohol and drug problems among older persons need to be addressed, despite the apparent low prevalence of such problems. As the population ages, even a small rate of problem use is likely to translate into increasingly larger numbers. In addition, there is some speculation that those who will become elderly in the near future are more likely to be drinkers and, therefore, more likely to have drinking problems, although the evidence is mixed as to whether drinking decreases with age (Adams et al., 1990; Busby et al., 1988; Glynn et al., 1984; Temple & Leino, 1989).

ADDICTIONS TREATMENT ISSUES PERTAINING TO OLDER ADULTS

There has been only a small amount of research on the treatment needs of older adults who have substance problems, or on the effectiveness of addictions treatment programs for older people. As the literature on treatment needs of older persons has grown, suggestions regarding treatment have been proposed based on identified characteristics of the target population. These suggestions have included: that treatment of older substance abusers requires knowledge of both alcoholism and aging and that the aged alcoholic is

particularly likely to fall between the cracks of the support service network (Rathbone-McCuan et al., 1976); that the older alcoholic is usually hidden, and therefore it may be necessary to involve outreach caseworkers in treatment (Duckworth & Rosenblatt, 1976); and that support services should exist for older alcoholics who cannot or do not want to be "cured" (Van de Vyvere, Hughes, & Fish, 1976). Other suggestions for treatment have been based on physicians' informal clinical experience with older persons who have alcohol problems. These include suggestions that there is a need for medical and supportive treatment; that treatment directed at social and psychological stresses is particularly useful (Droller, 1964; Rosin & Glatt, 1971; Zimberg, 1978a); and that service delivery needs to involve outreach, case-finding, and home-care (Zimberg, 1978b). Also on the basis of clinical experience (in a geriatric center), Rathbone-McCuan suggested that a comprehensive assessment is an important part of treatment (including case identification), and that community agencies need to work together in designating one resource for inpatient treatment and in providing ongoing case management (Rathbone-McCuan, 1982). Rathbone-McCuan also recommended that a suitable typology for helping the older problem drinker could be based on the presence or absence of (1) alcoholism or symptoms of problem drinking, (2) health problems, and (3) difficulties or inadequacies in the social network (Rathbone-McCuan & Bland, 1975).

A distinct issue that has emerged in the literature is whether there is a need for elder-specific treatment. While early views on the subject (based on clinical experience) promoted the need for special programs for older people who have substance problems, Hinrichsen (1984) surveyed staff in 40 alcoholism treatment programs in six states and found that the majority (84 percent) felt that age-segregated treatment was unnecessary. However, recent data suggest that those who receive elder-specific treatment remain in treatment longer and are more likely to complete treatment than those in mixed-age outpatient groups (Kofoed et al., 1987).

In sum, specific considerations for treating older substance abusers have received very little attention until recently. The prevailing views of those who have written on this topic include the following: that outreach is required, that age-specific programs may be desir-

able, and that non-confrontational individual or group approaches based on providing social and medical support are likely to be most useful. There is also some evidence that older alcoholics do at least as well in treatment as younger alcoholics (Carstensen, Rychtarik, & Prue, 1985; Hanson, 1988; Linn, 1978).

Chapter 2

The Development of the Community Older Persons Alcohol (COPA) Program

The following is extracted from a recent paper by Graham, Saunders, and Flower (1990) and describes the background that led Dr. Sarah J. Saunders to establish the COPA project:

> In the late 1960s when I first started working in the field of addictions, the conclusion of the research literature was essentially that older people did not have alcohol problems. This view was partly based on the fact that very few people age 65+ ever entered an alcoholism treatment program and consequently were not visible to those persons in the alcoholism treatment field.
>
> Then, when I was invited to develop a treatment program for a group of actively drinking men, creating behavioral havoc in a large home for the aged, it seemed like an interesting challenge but a rather low priority. Fortunately, I had the time to respond. I was aware that Alcoholics Anonymous had been involved in the home for 18 months with all contact being totally refused by these residents. What evolved was a quasi-behavioral program that seemed to work after about 9 months–work in the sense that the behavior problems and frequency of intoxication dropped significantly (according to daily records of alcohol use and related behavior). Associated with this drop was a significant improvement in socializing skills and non-alcohol-related use of leisure time. At no time did the residents acknowledge a problem with their use of alcohol. This concept was important in the development of future programs.
>
> Over the next 8 years as this program was enlarged, I began receiving many requests from the community for assistance

with elderly alcohol abusers. I noted that most of these requests came from home caregivers. Consequently, I began making home visits with community health nurses to see if indeed there was a population of elderly alcoholics who were not being identified–there was!

Common themes that emerged were:

- most refused to leave the home for almost any reason
- many demonstrated problems related to alcohol use in every aspect of their lives
- most totally resisted any suggestion of formal treatment for alcoholism
- many identified needs that seemed to be quite different from those of younger alcoholics.

What I learned from this experience was that given the opportunity to resolve some of their more acceptable problems (health, housing), helping them make the link between these problems and their use of alcohol was also often possible. We found that working with people on other problems often seemed to lead to their reducing their alcohol consumption, although total abstinence occurred in only a few people. However, even without total abstinence, the majority of those persons visited seemed to improve significantly in terms of living arrangements, health, non-alcohol-related socializing and leisure activities, as well as reduced alcohol consumption. We also found that because of the multiplicity and variety of lifestyle problems, many other agencies and services needed to be involved in the therapeutic process.

We seemed to have identified a hitherto unrecognized population of elderly alcohol abusers, and had developed a means whereby treatment was possible and apparently effective. By January 1981 I was receiving requests to develop a formal treatment program for elderly persons living in their own homes. A planning committee was formed that included representatives from all the major gerontological resources in Toronto as well as the Addiction Research Foundation (ARF). The concept for the COPA program was developed in May 1981. When taking into account all the themes identified in the

> earlier project, the new program bore little resemblance to existing alcohol treatment programs either in the treatment goals, methodology or program content. (pp. 197-198)

In 1983, the Community Older Persons Alcohol (COPA) Program was established in West Toronto. The program was developed specifically to meet the needs of hard-to-reach older people who have alcohol or drug problems and was structured on three major principles: (1) that outreach should be provided where appropriate to older people who have substance problems, rather than assuming (as with traditional addictions programs) that persons should come *to* the program; (2) that it was not necessary for clients of the program to acknowledge substance problems in order for meaningful change to take place (again, a principle in direct opposition to traditional addictions treatment approaches); and (3) that one important goal of addictions treatment for older persons is to maintain the independent living of these persons in the community (by linking them with necessary community supports).

For the purpose of this book, Margaret Flower (the first director of COPA) provided the following reminiscences regarding the delivery of the program in its early days:

> Travelling uncharted areas, we had no "clinical model." We went with hope, learn on the job, do no harm, and improvise.
>
> What I *think* we did was:
>
> a. Responded immediately to the problem(s) identified by the client–regardless of its origin (i.e., even if not directly related to substance abuse), building trust, rapport, providing immediate support, and providing case management. This was done with "high intensity empathy!"
> b. Kept clear definitions of the client's goals versus "our" goals–my feeling is that much of this was done at staff meetings through case consultation. These meetings provided a forum for keeping perspective on clients' strengths and achievements (small goals) and ensuring that our motives were in the clients' best interests. Since the program was innovative and we were not able to measure our work

against existing programs, these meetings helped to affirm that we were on the right track.

c. Some of the issues that we had to deal with included: What would happen when we disengaged–would the client relapse? Did we recognize our limitations? How could we involve other supports (e.g., other agencies, families)? Probably treatment is the wrong word for our approach. What we tried to do was introduce a new element for the client–*choice*.

"Accepting" the client and being there for them became an actuality, not just a phrase. It started with visiting homes, often in total squalor (reflecting not just the addiction limiting the individual, but often physical, mental and emotional barriers to care). Being non-judgmental was crucial. We had to be open to the possibility that the living circumstances were the free choice of the individual. Assessment included the client's satisfaction with the existing lifestyle.

It was necessary that we recognize the strengths and past achievements of the client and verbalize this recognition to the client. It was with some difficulty that we developed the patience and skills to elicit this information from clients *and* to recognize its value as part of treatment.

Doing the conventional aspects of treatment were relatively easy: assessing needs, prioritizing needs, and facilitating help and support from agencies and family. These aspects of the job tended to provide us with a sense of accomplishment and satisfaction–that we had "improved" someone's situation. On the other hand, to be prepared to allow the client to determine what treatment was necessary/acceptable/least intrusive was a more frustrating process. Accepting that no treatment was necessary or wanted was a scary experience.

Generally, the treatment, then as now, consisted of an extensive period of assessment and engaging the client in treatment followed by a variety of actions, including support, practical help, referral, problem solving, and sometimes confrontation. In the following

section, the courses of treatment for two COPA clients are described in detail to demonstrate the application of the COPA philosophy.

THE COURSE OF TREATMENT FOR TWO COPA CLIENTS

The following sections describe in detail the course of treatment for two COPA clients. First, an overall summary of each case is provided, followed by a treatment summary where each contact with the client during treatment is described, as well as other events where applicable. Each treatment summary is fairly complete, but may underestimate the number of contacts with the client, as phone calls and other brief contacts with the client (e.g., meeting on the street) were often not documented.

These cases are also included in the typology (Chapter 3): the first client described here appears as Case 10, and the second client is Case 15. These cases were chosen to demonstrate the variability and complexity of older substance abusers and their problems. They also demonstrate the flexible approach to treatment taken by the COPA counselors.

Client 1: Case Summary

At referral, this 64-year-old man was spending all his time in his rented room eating very little, and in deteriorating physical health. He was profoundly depressed, isolated, and inactive. Because of his poor health and lack of mobility, he was not drinking, but according to the community nurse who referred him, the client had a long history of alcohol abuse (possibly skid row alcoholic lifestyle).

Initially, the client was very passive and did not respond to program efforts to improve his circumstances. After a couple of months, he appeared to welcome the emotional support and practical assistance and developed a close relationship with the program counselor. During the early phases of treatment, the focus was on improving the client's immediate housing, financial, physical, emotional, and nutritional problems. After his initial crisis was resolved, the areas of focus for intervention began to include reducing alcohol

consumption and promoting better social/leisure activities, better care of self and home, and appropriate use of medications. During aftercare, the program worker provided ongoing support and practical assistance to the client where needed. During treatment, he was seen over a period of 29 months at 60 home visits, several chance meetings, and several contacts to help him pick up furnishings. In addition, there were numerous telephone contacts with or about him. During treatment, the client was seen by a visiting nurse, a community health clinic, Meals-on-Wheels, welfare, housing authorities, a GP, a seniors' information center, the Mission, and a public trustee.

Over the course of his treatment, the client exhibited improvement in assertiveness and self-esteem. Although the initial goal for the client was to find a good boarding home, by the end of treatment the client was maintaining independent living in his own apartment (obtained through subsidized housing) and he was taking good care of himself and his apartment, eating regularly, getting exercise, and engaging in satisfying social activities and recreation. Although the client continued to drink throughout the program, he was able to reduce his intake to a level that did not appear to be detrimental to his physical health or his well-being in other life areas. He had several relapses into heavier drinking during his treatment, but by the time he was discharged these bouts had been reduced.

At the follow-up stage of the research (about two and a half years after discharge), the client was contacted by telephone. He reported that he was doing fairly well and managing to live on his own in an apartment. He had problems with arthritis that hampered his activity somewhat, but was able to engage in some activities and was in fair spirits. He reported that his current alcohol consumption was about 12 beers on weekends. He felt that the program had provided a great deal of help and mentioned the counselor by name and how helpful he had been.

Client 1: Treatment Summary

[Counselor's actions or responses are in brackets.]

1. *Initial home visit with public health nurse.* Client has no money, no food, and no cooking facilities. Meals-on-Wheels (three

times/week) seems to be his only food. He has been losing weight, experiencing blackouts, and says he has no feeling in his legs below the knees. [Assessment.]

2. *Home visit (8 days later).* Client is still eating poorly and experiencing vivid dreams, possibly hallucinations. He is depressed and hopeless. [Assessment.]
3. *Home visit by COPA counselor with a physician (2 days later).* Client has been abstinent for several weeks due to lack of money. He has fits (possibly epilepsy) and frightening dreams. He is nervous and isolated. [Recommendations: (1) he should have accommodation where he is provided three meals/day; (2) medical check-up as soon as possible; and (3) psychogeriatric assessment.]
4. *Home visit (5 days later).* Situation is unchanged and client refuses to do anything.
5. *Telephone call (2 days later).* Client says food from Meals-on-Wheels has not been delivered. [Counselor offered to bring him food.]
6. *Home visit (same day).* Meals-on-Wheels had arrived. Client was cheerful and had washed his face and combed his hair. [Counselor brought client food and commented positively on his appearance.]
7. *Home visit (6 days later).* Client is very concerned about his health, but he also has a defeatist attitude and refuses to address problems. [Counselor and client discussed client's boyhood.]

   [Case notes: Referral has been made for psychogeriatric assessment. The public health nurse is going to contact client's sister to see if she will provide some support.]
8. *Home visit (20 days later).* Client is in poor physical health. He is defeatist about changing accommodation or dealing with health problems. [Counselor made suggestions about alternate accommodations.]
9. *Home visit with second COPA counselor who will be taking over case (28 days later).* Client is still not drinking and health is still poor. He is lethargic, depressed, and hopeless. He perked