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Introduction

Knowing how to help or how to best direct your staff to help older people with substance use, mental health or gambling problems is often difficult. Some service providers feel it is "too late" for older people to change or that working with people with these types of problems is not their responsibility. Others want to help, but feel that the resources they have at hand are inadequate, that they lack specific expertise or that they cannot begin to offer what is needed.

Because service providers are often unsure of whether or how they can help, some wait until a crisis occurs, by which point problems may have become even more complex and difficult to address. If the older adult in crisis doesn't already have positive relationships with service providers, he or she may turn down offers of help. Frustrated service providers may interpret this refusal in negative ways, labelling the older adult as "difficult," "non-compliant" or even "manipulative" and may dismiss the situation as hopeless.

Substance use, mental health and gambling problems in older adults often go unrecognized or are mistaken for signs associated with aging or other problems. As a result, problems that may be reversible or treatable are not considered. When problems are identified, the stigma associated with the condition often prevents older people from talking about it and from seeking help. However, research has shown that older persons do as well or better than their younger counterparts when they are treated for depression or substance use problems (Canadian Coalition for Seniors' Mental Health, 2006b; Gurnack et al.,

2002). Growing clinical experience and research indicates that many of the mental health issues of late life can be ameliorated and "functional decline" (a decline in older people's physical and cognitive abilities) can be slowed down, if symptoms are promptly assessed and treated. Like people of any age, older people deserve appropriate care and treatment.

Due to an increase in life expectancy as well as the aging of the baby boomer generation (those born between 1946 and 1966), older adults are the fastest growing segment of the Canadian population. In 2000, about 13 per cent of the Canadian population was aged 65 and older; this percentage is expected to grow to 19 per cent by 2021, and to 25 per cent by 2041 (Health Canada, 2001). As the number of older adults increases, so too will the number of older adults with substance use, mental health and gambling problems.

You can prepare for the challenges this increase will present by learning ways to address these problems more effectively. You do not need to become an addiction or mental health counsellor. The role you have already may offer a unique and important opportunity to intervene and have a positive impact. The information and strategies provided in this guide will give you the knowledge and tools needed to identify issues early on, to understand what help is available and is appropriate for the older client, to prevent problems, avoid crises and to continue to support the person over time. Additional resources are given to continue to build knowledge, expertise and community capacity to respond to problems.

Defining a problem

Problems may not always be obvious. For example, not every older adult who drinks alcohol, worries about his or her health or plays the lottery has a problem.

There are many ways to define problems, but perhaps the simplest way is to determine whether a person's substance use, gambling or mental health is having an ongoing negative impact on the person's life, or on the people who are close to that person. These negative impacts can go far beyond the immediate symptoms to affect every aspect of a person's life, including his or her physical and emotional health, thought processes, social and family life, housing, finances and ability to live independently.

What is a substance use problem?

Substances that can cause problems include alcohol, prescription and over-the-counter medications and illegal drugs, such as marijuana. When people have a substance use problem, they may:

- experience additional or worsened health problems (e.g., falls leading to hospitalization); they may also experience ongoing tension with family and friends or housing problems (e.g., eviction)
- have problems fulfilling obligations (e.g., caregiving, keeping appointments, paying bills)
- have legal difficulties as a result of drinking and driving, alcohol-related disorderly conduct or spousal abuse
- be unable to stop or reduce use despite experiencing serious health problems or social consequences
- engage in substance-seeking behaviour such as doctor shopping (asking for care from many different doctors) or "double doctoring" (seeking

prescriptions for the same medication from different doctors)
- have difficulty accessing needed services because of substance-use related behaviours.

WHAT ARE SUBSTANCE DEPENDENCE AND ADDICTION?

The term *substance dependence* can be confusing because it has both psychological and physical components. The term *addiction* is also often misunderstood.

Psychological dependence occurs when a person feels he or she needs a drug to function or feel comfortable, for example, needing to drink alcohol to feel comfortable in social situations or needing to take a sedative to be able to sleep. Eventually some people may feel they need a substance just to be able to cope with daily life.

Physical dependence occurs when a person's body has adapted to the presence of a drug. *Tolerance* has developed, which means that the person needs to use more of the drug to get the same effect. When drug use stops, symptoms of *withdrawal* occur.

Addiction always involves psychological dependence, but it may or may not involve physical dependence.

People often think that psychological dependence on a substance is not as serious as physical dependence. This is not necessarily true. While physical dependence can result in uncomfortable and even dangerous symptoms of withdrawal (e.g., nausea, tremors, seizures) when substance use is stopped, these symptoms usually disappear fairly quickly, that is, within hours, days or weeks. The cravings, triggers and compulsive behaviours associated with psychological dependence can take much longer to fade after substance use stops. They can last for several months or even years. Overcoming psychological dependence is often the greater challenge.

Some substances produce psychological dependence without physical dependence (e.g., cocaine); others can produce both psychological and physical dependence (e.g., alcohol, benzodiazepines, nicotine, opioids). It is also possible to become physically but not psychologically dependent on a substance. This is sometimes seen in people who take opioid medications such as Tylenol 3, Percocet or morphine for the treatment of severe pain. Once the body heals and the pain subsides, they are able to stop taking a pain-relieving drug gradually, without feeling a further need for it. Others, however, do develop a psychological dependence on prescription pain-relieving drugs and may require support, either to ease off these medications, or in the form of a longer-term methadone or other opioid replacement maintenance treatment.

Specific substance use problems in older adults are discussed in the sections on Alcohol, Illegal Drugs, Medications and Tobacco in Chapter 3.

What is a mental health problem?

Feeling sad or worried, having unusual thoughts or forgetful moments is most often normal. Everyone has these feelings and experiences at times. The distinction between normal emotions and thinking and a mental health problem is that a person with a mental health problem has:
- several symptoms
- symptoms that continue for a long time
- symptoms that cause distress and interfere with his or her ability to function in terms of self-care, work, leisure or relationships.

For example, symptoms of depression may include loss of interest or pleasure in daily activities,

irritability, loss of energy and change in appetite. For depression to be diagnosed, the symptoms must persist for at least two weeks, most of the day, almost every day (American Psychiatric Association, 2000). An older person with depression may not eat well and may lack proper nutrition, lose interest in hobbies and become isolated.

Mental illness impairs a person's thoughts, mood and behaviour. It is caused by unregulated brain chemistry, sometimes complicated by life circumstances, such as trauma or abuse, which may trigger the illness. Research points to a genetic factor in disorders such as schizophrenia, bipolar disorder and major depression.

Mental illnesses tend to be episodic or cyclical; a person may have episodes of acute illness, but also long periods of wellness. The exception is dementia with a continuing decline of function. The presence and course of mental health problems in older persons vary considerably in terms of their general health, diet, care setting, access to social supports and other life factors.

A strong support network that offers security and a sense of control over circumstances may help a person with mental illness to cope with his or her symptoms. Older persons with dementia or other late-life problems are more likely to have a strong social support network than people with long-term chronic mental health issues, such as early-onset schizophrenia or bipolar disorder. By the time people with long-term severe mental illness reach old age, they often have little or no contact and support from family. This can result in poverty, isolation and hospitalization.

MENTAL HEALTH PROBLEMS IN OLDER ADULTS

Mental health problems seen in late life include anxiety disorders, depression, personality disorders, psychotic disorders, dementia and delirium.

Anxiety disorders and **depression** can hit people in their later years, even when they have not experienced these problems as younger adults. The physical, social and economic losses associated with normal aging can overload people's emotions, making them more vulnerable to these mental health problems.

Personality disorders or **psychotic disorders**, such as schizophrenia, that were present early in life often persist into old age. Symptoms or behaviours may either increase or decrease over time. Schizophrenia may also develop later in life, after age 40 or even after age 60.

Dementia is the most frequent cause of behavioural problems in older adults. The longer a person lives, the greater the chance of developing a dementia.

Delirium in older persons is often misdiagnosed or under-recognized. Symptoms such as confusion, disorientation and a clouding of consciousness can all be found in other types of mental health problems. However, with delirium, the symptoms usually begin abruptly, for example, after surgery, and may last only a few days. If left untreated, delirium can become a more permanent cognitive problem. Delirium is considered a medical emergency.

Each of these problems is discussed in greater detail in Chapter 3 of this book.

What is problem gambling?

Not all people who gamble excessively are alike, nor are the problems they face. People with gambling problems are found in all age groups, income groups, cultures and jobs. Some people develop gambling problems suddenly, others over many years.

There are many reasons why a gambling problem may develop. For example, some people develop problems when they try to win back money they have lost, or because they like the excitement of being in on the action. Others have many life stresses that make gambling a welcome relief.

Problem gambling is not just about losing money. Gambling problems can affect a person's whole life.

Gambling is a problem when it:

- gets in the way of work, school or other activities
- harms a person's mental or physical health
- hurts a person financially
- damages a person's reputation
- causes problems for a person's family or friends.

Information on gambling in older adults is provided in the section on Gambling on page 60.

What are concurrent disorders?

A person can be said to have *concurrent disorders* when he or she has both a substance use and a mental health problem.

The term *concurrent disorders* is used in Ontario; elsewhere, such as in British Columbia and the United States, other terms are used, including *comorbid* or *co-occurring disorders*, *complicated chemical dependency* and *dual diagnosis* (in Ontario *dual diagnosis* refers to co-occurring developmental delay and mental health problems).

Concurrent disorders vary in severity and in type and include people with:

- significant but milder mental health and substance use problems
- substance-induced or exacerbated psychiatric disorders
- severe and persistent substance use and mental health problems.

The most common combination of concurrent disorders is co-occurring substance use and mood and anxiety disorders. Following that, in order of occurrence, is co-occurring substance use and severe and persistent mental disorders (e.g., schizophrenia), personality disorders and eating disorders (Health Canada, 2001).

When working with people with either a mental health or substance use problem, concurrent disorders should be considered "an expectation, not an exception" (Minkoff, 2000). Many, if not most people receiving services for a mental health or substance use disorder have concurrent disorders.

THE RELATIONSHIP BETWEEN SUBSTANCE USE AND MENTAL HEALTH PROBLEMS

The relationship between substance use and mental health problems differs from person to person. It is not always possible to understand which came first. However, it is important to understand that the two problems often influence and affect one another. For example:

- People with mental health problems are more vulnerable to substance use problems. They tend to develop problems at lower levels of substance use and may use substances to attempt to relieve their psychiatric symptoms.
- Substance use can induce psychiatric symptoms. Alcohol, for example, when used heavily over a period of time can cause symptoms of depression. Substance use can also lead to psychosocial problems that may in turn lead to mental health problems.
- A common genetic, developmental or environmental factor could trigger both problems. A traumatic event, for example, such as a sexual assault, could lead to both mental health and substance use problems.

- Mental health and substance use problems may not interact: even when one is under control, the other may still be active (O'Grady & Skinner, 2007).

The continuum of severity

As with many health conditions, substance use, mental health and gambling problems can range in intensity from mild to severe. Factors defining the severity of problems include the duration of the problem and the number of symptoms or other negative effects. Severe problems may arise once in a person's life, for example, in response to a life event, or they may be ongoing and fluctuate in intensity over time. Changes in life circumstances, such as retirement or the death of a loved one, may trigger a problem or the return of problems. Mild forms of mental health problems may worsen if untreated; service providers, families and individuals themselves have a role to play in identifying potential mental health problems as early as possible.

Recognizing problems

Signs of substance use, mental health and gambling problems often go unrecognized. Dementia and depression, in particular, are frequently not recognized. Signs may be ignored, attributed to the effects of aging (e.g., forgetfulness or confusion) or mistaken for signs of another problem (e.g., signs of depression, substance use problems and dementia may be similar). Symptoms of mental health problems in later life, such as anxiety and even psychosis (e.g., oddness, eccentricity or fearfulness), might be viewed as typical in an older person ("just a normal part of growing old"). Some people assume that older adults don't have substance use or gambling problems, or think that few if any older adults drink or take other drugs at all; or they may believe that drinking is good for people in later life. They may consider gambling or drinking as pleasant, harmless activities that keep older adults from becoming lonely or bored. Not being aware that gambling can lead to serious problems and the absence of obvious signs of potential problems may contribute to a low rate of recognition of gambling problems (World Health Organization and World Psychiatric Association, 2002).

Older people may not be willing to discuss or admit their problems with substance use, mental health and gambling because they feel ashamed, or they believe that such issues should be dealt with privately. To hide the problem, they may isolate themselves. Some live in isolation for many years before a crisis—typically a problem with their health or housing situation—brings them to the attention of service providers.

Receiving help that specifically addresses problems at an early stage, before they escalate, may prevent the need for treatment and set people on a healthier course so that they can enjoy life, pursue interests and handle caregiving or other responsibilities. Interventions may be as simple as providing information to the older person to educate him or her on the issue (such as the information sheets provided on page xx). People with difficulties of a more intense nature may benefit from more formal interventions, such as brief counselling or a referral to a qualified specialist. Severe problems may require urgent medical attention. Understanding the condition and the older person's history can help you to recognize the severity and to access the needed support.

Aging can increase vulnerability to problems

Most people age well and are able to continue to apply or adapt the coping mechanisms they have developed over their lifetimes to deal with the stresses, losses and transitions often associated with aging. However, the challenges of the following age-related changes can increase some older adults' vulnerability to problems with substance use, mental health and gambling. No one factor will necessarily cause a problem, but it may increase the risk, especially when combined with other factors.

Older adults' vulnerability to problems may be increased by:

Physiological changes: As people age, changes in metabolism, body fat, body water and body size can cause alcohol and some medications to have an increased effect.

Changes in mental capacity: Cognitive impairment can increase stress and anxiety and affect judgment regarding substance use and gambling.

Losses in ability: The loss of physical abilities such as mobility, hearing or vision can reduce a person's ability to engage in activities that once gave pleasure, enjoyment and independence and can also increase isolation.

Loss of social networks: Significant gaps in support may be created by the loss of social networks, for example, through retirement, relocation, reduced mobility, death, separation or divorce.

Other losses, changes and transitions: Older adults often experience many cumulative losses and changes; for example, leaving the family home, mourning the death of a spouse or friends and losing their independence. These losses, particularly if the person's repertoire of coping strategies no longer works, may compound and increase his or her vulnerability to trauma, grief and despair.

Pain, insomnia and stress: Physical and emotional stress that is not adequately or appropriately addressed, or that worsens over time, can also affect someone's ability to cope. Research has shown that older adults use both alcohol and medication to treat psychological symptoms (e.g., to relax, to promote sleep, to relieve tension or anxiety, to forget worries and to relieve pain). This behaviour places them at risk for substance misuse, abuse and dependence (Graham et al., 1996; Health Canada, 2002).

Other physical conditions: Heart disease, digestive problems, arthritis and other health conditions ranging from mild to severe can also challenge an older person's ability to cope and increase his or her use of prescribed and over-the-counter medications.

A reduction in financial resources: Having less money can affect a person's choice of or access to housing, food, clothing, transportation and health care.

A spiritual shift in values: As people age, the meaning they attach to material goods, social relationships, success and failure and life itself may change; life may seem meaningless.

These realities may lead older adults to try to escape their difficulties, mask them or self-medicate through substance use or gambling. Such stresses and shifts may also precipitate or exacerbate mental health problems and increase the risk of problems with medications.

Ageism and other forms of stigma

In North American society, most of our attention and resources are focused on younger people while older people tend to be marginalized and undervalued. Older adults may experience prejudice, stereotyping and discrimination simply because they are perceived or defined as "old" (American Psychological Association, 2004). They may be treated as invisible or worthless or seen as a drain on society.

The term *ageism* refers to attitudes about older people and their abilities. Age discrimination is a consequence of ageist attitudes. Ageism affects the individual and also the availability and design of programs and services, which may result in the absence of community resources to meet the needs of older adults. Services designed for adults in general may not recognize or accommodate older people's needs and issues, while services that are specific to older adults are often scarce and underfunded. Intentional and unintentional discrimination against older adults is commonplace in many service delivery areas (Ontario Human Rights Commission, 2001).

Stigma affects people of all ages with substance use, mental health and gambling problems. Stigma refers to negative attitudes (prejudice) and negative behaviour (discrimination) toward others. The impact of negative staff attitudes or behaviour, whether purposeful or unconscious, can adversely affect the services and care that people receive. Older adults have had many years to absorb this stigma, shame and loss of self-worth, and they may have come to believe that the many forms of discrimination they may experience in later life are warranted (Baker, 2006). When ageism is added to the mix, the burden of the stigma of having a substance use, mental health or gambling problem is multiplied (Centre for Addiction and Mental Health, 2005).

Ageism and other forms of stigma create barriers

Certain attitudes and expectations can undermine the response of people working with older adults. Services might be withheld or denied when service providers or the policies of their agencies deem older adults to be:

- taking up space that should go to "more deserving" patients or clients
- unable to qualify for certain services (e.g., home care, personal support, mental health or addiction services) until they get help for their mental health, substance use or gambling problem
- inflexible and unable to change
- non-compliant when they refuse services that they feel are not appropriate to their needs or that do not match their priorities.

Older people with substance use problems can be caught in a "revolving door" of going to emergency, being bounced between medical and social services or being denied services. They may be shunned and shamed (e.g., referred to as an alcoholic or a drunk), treated as invisible and ignored, or given less latitude and treated with less respect than other people. Older people with mental illness often receive poor quality treatment and care. They may be marginalized within systems, "warehoused" outside the health care system or institutionalized unnecessarily. They may also experience poor quality of life and material and financial inequity (World Health Organization and World Psychiatric Association, 2002). People

with dementia may be written off as being unable to enjoy any aspect of life; depression can be judged as mere laziness. How gambling problems might develop in later life may be hard for some service providers to understand; the person may be seen as foolish or greedy and deserving of whatever happens to him or her, rather than as someone who needs help.

Older adults may internalize society's ageist attitude and feel further shame about their mental health, substance use and gambling problems. Ageism and other forms of stigma lower self-esteem and prevent older adults from seeking or receiving help from appropriate services. Older adults may avoid seeking help because they:

- don't see themselves as having a problem
- feel they should be able to deal with their own problems and not ask for help
- may not know that help is available or know where to find it
- feel ashamed and want to hide their problems
- want to protect their family's reputation
- fear repercussions (e.g., legal problems, being placed in a home)
- have experienced disrespect from service providers
- find few or no services targeted at older adults in their area
- feel hopeless that the situation can be improved
- don't see themselves as deserving help.

Ageism and stigma feed on ignorance and fear. When people develop a greater awareness and understanding of aging and of how substance use, mental health and gambling problems develop, knowledge and understanding replace ignorance and fear, and ageism and stigma will diminish and disappear.

Diversity

As an age group, older adults are the most heterogeneous (American Psychological Association, 2004). They range in age from 55 to 100. Within the older adult age group, certain groups of older persons may face discrimination and disadvantage in addition to ageism and stigma, increasing their vulnerability to mental health and substance use problems or intensifying existing problems. These groups may also face significant additional barriers to health care and social services. Awareness of some of the unique issues affecting these groups can help service providers to respond to their special needs.

Gender

Older women and men differ in that:

- women tend to live longer than men and are therefore more likely to:
  - care for infirm husbands and ultimately outlive them
  - act as caregivers and to carry more of the burden of home care concerns than older men (Ontario Human Rights Commission, 2001)
  - experience age-related problems such as dementia and other medical conditions (American Psychological Association, 2004; Ontario Human Rights Commission, 2001)
- older women tend to have fewer financial resources than older men (American Psychological Association, 2004; Ontario Human Rights Commission, 2001)
- women are more prone to intoxication and to substance use problems at lower levels of substance use than men because women's bodies metabolize alcohol and other substances differently than men's bodies

- older men are at especially high risk for suicide; in 1997 the suicide rate for older Canadian men was nearly twice that of the nation as a whole (Canadian Coalition for Seniors' Mental Health, 2006c)
- men are more likely than women to drink heavily and more than twice as likely to be dependent on alcohol (Tjepkema, 2004).

Disability

In Canada, 35 per cent of all people with disabilities are seniors; many of these disabilities develop in later life. The most common disabilities among seniors are those affecting mobility (74 per cent), physical flexibility and agility (65 per cent), hearing (42 per cent) and vision (26 per cent) (National Advisory Council on Aging, 2005a). Other disabilities include psychiatric, developmental and cognitive challenges.

Older adults with long-term disabilities may have had lifelong problems with employment, transportation, housing and discrimination. Aging can aggravate chronic patterns of poverty and social discrimination among people with disabilities (Ontario Human Rights Commission, 2001).

When disabilities arise in old age, they are likely to cause a sudden change in the older person's life circumstances and may precipitate a rapid decline. Either way, older people with disabilities may have high levels of stress, pain, social isolation and they may be more vulnerable to abuse from others. All these factors can affect their ability to cope and increase their vulnerability to substance use and mental health problems. Issues of transportation and accessibility may limit their access to treatment services and other community supports.

Sexual orientation and gender identity

A person's sexual identity is a central and important part of who that person is throughout life, including old age. When people feel they must keep this aspect of their personal identity hidden, it prevents them from living and expressing themselves fully. This can have a negative affect on their mental health.

People who are lesbian, gay, bisexual, transsexual, transgendered, two-spirit, intersex or queer (LGBTTTIQ) face discrimination from people they know, from strangers and from health care, social service and senior service providers. While rates of substance use and mental health problems are high in these communities (National Advisory Council on Aging, 2002), many people do not access care because of fear of discrimination and stigma.

LGBTTTIQ people may have developed an alternative family structure of support, which may not be recognized or welcomed by mainstream services. Many of the present generation of older people who are LGBTTTIQ may have hidden lives or go "back into the closet" to avoid facing the discrimination of service providers.

Ethnocultural groups

Attitudes toward older adults and their expected role in society vary broadly among ethnocultural groups. Some regard older adults highly for their experience and wisdom; others downplay older adults' ideas and knowledge, viewing them as outdated. Ethnocultural groups also vary in their understanding of mental health, substance use and gambling problems. These factors influence older adults' risk of and resilience to developing problems, the level of support available to them,

and the attitude older people have toward seeking help for these problems.

Some immigrant seniors experience high levels of isolation and low levels of awareness of available supports such as transportation and health and social services. The immigrant experience may intensify fears of economic dependency and lessen the elder's status within the family.

Language barriers, lack of "cultural competence" and discrimination toward ethnocultural groups among mainstream service providers can prevent people from seeking or receiving the help they require.

Problems are complex

Substance use, mental health and gambling problems can affect and be affected by every aspect of a person's life. Mental health conditions such as depression or anxiety may lead a person to try to cope with or manage symptoms through substance use or gambling. In turn, these problems may result in health, social or financial problems, placing additional strain on a person's mental health. Often it is difficult to determine which problem came first or how to begin to address the various related problems. Because of this, it is important for service providers to be sensitive to the broad array of factors that can contribute to problems and to focus on the whole person, rather than only on the one problem that seems most obvious and troubling.