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# Approaches to Caring for Older Veterans with Chronic Addiction: A Guide for Staff

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**Approaches to Caring for Older Veterans with Chronic Addiction:**

**A Guide for Staff**

by

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## Chapter 1: Introduction

What does it entail to “help “the older adult veteran who is addicted to drugs and or alcohol? Is there a time in their lifespan we no longer can expect them to continue to attempt recovery from their addiction? It would not be difficult to find the older addicted veteran who suffers from other psychiatric illnesses along with life limiting diseases. What type of education do paid caregivers of the older addicted veteran need to increase their level of awareness as it pertains to symptom management associated with chronic illnesses. What resources would be beneficial to paid caregivers to assist the older addicted veteran in finding some peace and closure as the end of life is near?

Many people use alcohol, illegal drugs and prescription drugs to self-medicate from psychological suffering. ‘Total Pain’ is a type of suffering described as “the state of severe distress associated with events that threaten the intactness of a person” (Hinshaw & Hinshaw, 2013, p. 122). Hinshaw and Hinshaw’s (2013) study demonstrates that this portion of the population bring a lengthy history of suffering with them as they come to the end stages of their life. Saxon, Etten, and Perkins (2015) note, age related changes increase the likelihood of those who are older than 65, and abuse alcohol to develop more problems with social, physical and psychosocial issues.

Knowledge of some of the barriers to good pain and symptom management of elderly patients as Rastogi and Meek’s (2013) study notes is an important aspect to improving the overall care of the older addicted veteran. According to Rastogi and Meek (2013) some barriers include, but are not limited to; time constraints, lack of proper training/knowledge

related to pain, symptom management, and lack of standardized protocols, personal biases towards addiction, and legal scrutiny.

The purpose of this project is the development of a guide, along with a power point presentation, explaining symptom management of chronic illnesses, palliative care and the concept 'Total Pain', as it relates to addiction. This would raise the level of understanding of paid caregivers on emotional pain and management of physical symptoms many older addicted veterans experience near end of life. During the development of this guide, research demonstrated the importance of educating paid caregivers to the many common symptoms those with chronic illness and addiction face.

The guide will review common symptoms people exhibit near the end of their life, which often times these symptoms are made worse when a person continues to abuse drugs and alcohol. The information would include management of the following symptoms- dyspnea, anxiety, depression, nausea, vomiting and pain (Matzo & Sherman, 2010). Providing a definition, potential causes, medicated and non-medicated forms of treatment would improve the level of understanding surrounding each of the above noted symptoms. Increasing the knowledge level for those who are paid to provide care to the older addicted and non-addicted veteran will improve their critical thinking skills and improve management of these symptoms.

Certain risk factors, related to chronic illness and substance abuse, can lead to frequent emergency room visits, hospitalizations and need for long term care placement due to an inability to care for themselves. When the older addicted veteran presents to a health care facility in need of treatment, many different models of care exist that can be used. These

include but are not limited to: Multidisciplinary, Holistic, Palliative and Hospice (Matzo & Sherman, 2010). Each model brings a somewhat different perspective in the approach to treatment, but the philosophies of care are similar.

For those who are not able to manage their addiction before they are considered to be in the final stages of their disease(s), a handout using palliative care and “Total Pain” philosophy and management of symptoms associated with various chronic illnesses, as a guide would be beneficial. The palliative care portion of the guide would focus on comfort care related to physical symptoms.

An increased level of understanding of physical symptoms near end of life may not be the only tool necessary to help increase the level of awareness for the paid caregiver in providing care to the addicted person as they deal with chronic illness. A need for education describing the psychological suffering and pain associated with addiction must be included in the guide (Hinshaw & Hinshaw, 2013).

Educating to the ‘Total Pain’ philosophy and palliative care as it relates to addiction and providing holistic care, would be beneficial and included in the guide. The term ‘Total Pain’ encompasses the complex nature humans experience related to suffering as Hinshaw and Hinshaw (2013) note. This philosophy states suffering can be experienced in four dimensions: social, spiritual, psychological and physical. It is important that those who want to relieve suffering are familiar with this concept.

The following literature review will discuss and reveal the reasons the development of a guide, intended to increase the level of understanding of the paid caregivers of the older addicted veteran near end of life is vital. The guide will provide increased knowledge for paid

caregivers of the symptoms associated with chronic substance abuse, chronic illness and how to manage these and provide quality care.

The guide will provide information on the following subjects: Palliative Care, Total Pain philosophy, dyspnea, anxiety, depression, nausea and vomiting and pain. Potential causes, medicated and non-medicated forms of interventions will be listed as a guide reference guide for paid staff. The ultimate goal is for the veteran to receive care from professional caregivers that have a high level of understanding of symptoms management as it relates to symptoms of chronic disease, especially care during their final journey.

## Chapter 2: Literature Review

Review of the use of certain terms, as it relates to substance use disorders is important. In the case of veterans, van Ree, Mirjam, Gerrits, and Vanderschuren (1999) explain that the misuse of drugs, for those who become addicted, arises from both a psychic nature and physical dependence. “When a drug produces a feeling of satisfaction, which requires continued use of a drug to avoid discomforts or cause pleasure, the person has developed psychic dependence” (van Ree et al., 1999, p. 344).

Physical dependence, as van Ree et al. (1999) notes, occurs when physical disturbances arise when the person does not use the drug. Dufour et al. (2014) describe the definition related to opioid abuse as the intentional use of this form of drug without a physician’s prescription for a current medical condition. This does not include accidental misuse of an opioid. Blazer and Wu (2011) note, the definition of alcoholism is not based on the amount of alcohol consumed but the presence of three or more criteria.

Jeong et al. (2012) study found the level of alcohol consumed by a person addicted, nullifies the protective factors of light drinking. Blazer and Wu (2011) note alcohol dependence guidelines require the presence of three or more criteria, tolerance, withdrawal and increased time spent in alcohol use, taking larger amounts and longer inability to cut back. Increased level of awareness of the physical and psychological suffering associated with those who are not able to manage their addiction, will help increase the paid caregivers level of understanding of symptom management of chronic illnesses. Will this type of symptom management may be applied to all those with chronic illness, the main focus of this paper is

the older addicted veteran. The use of the terms addiction, abuse and substance use disorder will be used interchangeably throughout this paper.

It can be difficult for those who do not suffer from addiction to alcohol or drugs to empathize with those who cannot seem to manage the physical and psychological need for these substances. An understanding of the extent to which this is a problem for older veterans is important. The Williams et al. (2014) study notes, veterans in an outpatient setting were screened for their level of alcohol use. Williams et al. (2014) determined 28% of veterans, age 18-90 screened positive for alcohol or substance use disorder. For veterans, age 55 and older, Bartels, Blow Van Critters, and Brockmann (2006) found 75% of those admitted to a psychiatric inpatient unit had dual diagnosis of substance abuse and psychiatric disorder(s). This was compared to those veterans with alcohol or drug abuse issues alone, they comprised 62% of those hospitalized to an inpatient facility.

### **Substance Abuse and Psychiatric Illness**

Many people with addictions suffer from a psychiatric disorder as well. Bartels et al. (2006) study revealed one-third of primary care patients, greater than 65 years old have a psychiatric illness. Of the older adults who reside in long term care, 65% to 95% may have a mental disorder. Depression and anxiety are the most common diagnosis. The information reveals veterans have an even higher incidence of addiction than non-veterans. Bartels et al. (2006) note 29-49% of older veterans living in long term care facilities meet the criteria to be considered as having a lifetime diagnosis of alcohol and substance abuse.

Data reveals this number is expected to rise not only for the older addicted adult who resides in long-term care but also those who live independently (Purvis, 2010). This rise is expected to take a toll on the health care system, which in part is related to the cost of inpatient and outpatient methods of substance abuse treatment.

Various modes of treatment for substance abuse exist, such as inpatient and outpatient. Review of why some forms of treatment are more successful than other is important as part of the formula to help improve the level of understanding for the paid caregiver, with the goal of more awareness while providing care to the older addicted veteran.

### **Models of Care for Substance Abuse**

Many different modes of treatment exist for addiction; some are inpatient based while others occur in an outpatient setting. Discussing why some modes of treatment are more successful in the management of sobriety is important. One study, McKellar, Harris, and Moos (2009) was specific to veterans receiving treatment for substance use disorder.

Participants in McKellar et al. (2009) study were male veterans diagnosed with substance use disorder (SUD) who attended treatment in a community residential facility (CRF). The average age of the participant was 42.4 at the time they entered the study. There were a total of 1,683 participants in the study who had completed treatment. They were part of a 1 and 5 years follow up study to analyze their progress after leaving the community residential facility. McKellar et al. (2009) notes many were unemployed, and had few available resources once discharged from treatment. The study further notes the importance of the proper resources being provided after treatment has been completed. When discussing the

success of a substance abuse program, the relationship between the client and counselor cannot be underestimated (McKellar et al., 2009).

One such relationship is therapeutic alliance. Meier, Donmall, McElduff, Barrowclough, and Heller (2006) describe therapeutic alliance as the quality of the relationship between the person seeking treatment and their counselor. The importance of the counselor's awareness of their therapeutic alliance with a client cannot be overstated; it can be one of the strongest predictors to whether a person will remain in treatment (Meier et al., 2006). Practitioners can use an alliance questionnaire or document in progress notes their perception of the client's level of alliance. If the person seeking treatment is exhibiting symptoms of poor alliance to their therapist, it may indicate the need for a new counselor (Meier et al., 2006). Review of the programs listed as self-help forms of treatment reveal how important the person's commitment to abstinence, is a factor in their continued sobriety years later.

Self-help groups such as Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) are the most frequently used resources for those battling addictions (McKellar et al., 2009). Review of the client's length of abstinence after one year is the best predictor to determine whether AA and NA are effective in the management of sobriety. McKellar et al. (2009) reinforce the importance of focusing on the client who is non-abstinent during the first year after receiving treatment. A four year follow up study conducted by McKellar et al. (2009) reinforced that clients who remained abstinent from drugs or alcohol after the first year benefited the most from the aftercare of a 12-step self-help program. There are times however, when those battling addiction need an intensive form of intervention (McKellar et

al., 2009). Even then, for some older veterans, being successful in their management of their addiction should no longer be the focus of their care. The focus should be changed to symptom management of other chronic diseases.

### **Physiological Effects of Drug and Alcohol**

The known physical effects of drug and alcohol abuse are well documented. Lang, Guralnik, Wallace, and Melzer's (2007) study demonstrated a relationship of the physiological changes that accompanies aging, and the fact older adults have a higher sensitivity when they do ingest alcohol. Saxon et al. (2015) note, many older adults suffer from multiple chronic diseases and the abuse of alcohol may compound these health issues.

The effect to the older adult's health, after ingesting alcohol, is related to the decline of body water content of those over age 65. Saxon et al. (2015) describe the health effects related to alcohol abuse by the various systems of the body. The effects on the central nervous system include; increased depression, slurred speech, memory impairment and more difficulty solving problems. Increased blood pressure, risk of heart attack and worsening of coronary artery disease is the effects on the cardiovascular system. Alcohol abuse, as noted by Saxon et al. (2015), can lead to low blood sugar, acidosis and cirrhosis of the liver. The gastrointestinal effects include such things as gastritis, and anemia due to the inflammation of the stomach. Malnutrition and electrolyte imbalance following nausea and vomiting may occur. The guide will provide increased knowledge for paid caregivers of the symptoms associated with chronic substance abuse, chronic illness and how to manage these and provide quality care.

### **Increased Risk of Fall's and Injuries**

Finkelstein, Prabhu, and Chen's (2007) study reveals that the older adult with substance abuse, mental health issues and the medication used to treat such things as depression and anxiety are at increased risk of falls. This is related to the fact that those with these types of mental health concerns, tend to be less physically active and have more need for assistance with activities of daily living. When an older adult has a substance abuse disorder and mental health condition, they may be at a greater risk for falls with serious injuries (Finkelstein et al., 2007). It is difficult to make clear the exact risk for falls related to a certain level of consumption of alcohol for those greater than 65 years old. The study done by Lang et al. (2007) established that those older adults who consume an excess of 14 or more standard drinks per week were at increased risk of falls. The combination of prescription drugs and alcohol can lead to falls, injuries and complications of other psychiatric illnesses and chronic conditions. Saxon et al. (2015) report approximately 50% of drugs prescribed generally used by older people can lead to serious health consequences when mixed with alcohol. Knowledge of the serious health risks associated with prescription drugs and alcohol is important for the paid caregiver. This includes the risk of the addicted, developing dementia. Many times alcohol is not the main cause of various types of dementia; but is considered a risk factor as noted by McCabe (2011).

### **Alcohol Abuse and Risk of Dementia**

Hulse, Lautenschlager, Trait, and Almeida (2005) discuss the protective factor of light to moderate alcohol use as it relates to the possible decreased risk in the development of dementia. It is the person who consumes greater than 13 standard drinks of alcohol per week,

and has apolipoprotein E (APOE) gene, were found to be more prone to dementia (Hulse et al., 2005). Moriyama, Mimura, Kato, and Kashim (2006) study reveals evidence of direct toxicity to the neurological system is poor as it relates to the development of a dementia. Although, Moriyama et al. (2006) go on to note, cerebral white matter loss, such as demyelination and loss of fibers can be attributed to alcoholism. Gerridzen and Goosnesen (2013) note Wernicke's syndrome, a form of encephalopathy, occurs secondary to chronic abuse of alcohol and thiamine deficiency. Korsakoff's syndrome is from acute Wernicke' for those who are unable to manage their abuse of alcohol. McCabe (2011) notes alcohol interferes with the absorption of thiamine and many alcoholics are malnourished which also contributes to Korsakoff's.

Many older adults suffering from Korsakoff's exhibit behavioral symptoms that can be difficult to manage. These include lack of awareness of their illness, sexual disinhibition, aggression and apathy (Gerridzen & Goosnesen, 2013). Many of the behaviors exhibited are treated with psychotropic medications in an effort to try and control them. Many times these medications are only somewhat effective and not free from the risk of side effects, such as falls (Gerridzen & Goosnesen, 2013).

### **Cost of Care**

Purvis (2010) notes, the prevalence of those using illicit drugs among the 50 years and over cohort is expected to rise due to this population having a higher rate of lifetime use. When 33 diseases are ranked on a national level based on cost of treating the illness, drug disorders is seventh (Purvis 2010). This is related to the fact that those actively abusing alcohol, using prescription or illicit drugs use health care at a rate twice as much as those in

the same age group with no issue with abuse. The estimated cost to the United States related to substance abuse is 151 billion dollars a year, which includes lost productivity, an inability to continue to hold a job, consequences of crimes committed and health care costs (Purvis, 2010). Review of the data specific to Medicare recipients notes a significantly higher cost of their overall health care versus those who do not battle abuse (Dufour et al, 2014).

Of the older adults receiving Medicare benefits, Dufour et al. (2014) reveals the rate of opioid prescriptions remained stable over a 6 month time period, but diagnosed opioid abuse increased from 3.17 to 6.35 among Medicare recipients, per one thousand. The financial burden is evident, “documented mean per capita annual direct health care costs from 1998 to 2002 of nearly \$16,000 for patients diagnosed with abuse compared with approximately \$1,800 for patients not diagnosed with abuse” (Dufour et al., 2014, p. 111). Purvis (2010) notes due to the baby boom generation being larger than the previous cohort and having a higher rate of illicit drug use, frequency of substance use disorders among older adults is expected to double by 2020.

The financial toll on the healthcare system applies to abuse of alcohol, illicit drugs and prescription drugs. Bartels et al. (2006) notes those older adults who have both a psychiatric illness and substance use issues, have a higher rate of use of the health care system. For veterans, age 55 and older, Bartels et al. (2006) found that 75% of those admitted to a psychiatric inpatient unit had dual diagnosis of substance abuse and psychiatric disorder. This was compared to those veterans with alcohol or drug abuse issues alone, they comprised 62% of those hospitalized to inpatient facility. The reasons for hospitalization are numerous, related to both physical changes that can occur with aging and abuse of drugs and alcohol.

Facilities use various models of care when addressing chronic disease management. These models of care treat a person's physical, psychological, mental and spiritual needs (Lugton & McIntyre, 2005). They include things such as multidisciplinary, holistic, palliative care and hospice care.

### **Models of Care**

The multidisciplinary care approach is a collaborative effort by a team of professionals. The multidisciplinary care approach "occurs when professionals from a range of disciplines with different but complimentary skills, knowledge and experience work together to deliver comprehensive healthcare aimed at providing the best possible outcome for the physical and psychosocial needs of the patient and their career" (Multidisciplinary Care, 2011, p. 453).

Holistic medicine acknowledges the complexity of each person related to his or her body, mind, spirit and emotions (Matzo & Sherman 2010). With holistic therapy, patients are taught tools on how to care for themselves and explore reasons that may stand in their way of not being successful (Matzo & Sherman 2010).

### **Palliative Care**

Palliative care is defined as a form of care with the goal of improving the overall quality of life for both the person with illnesses with no cure and their family (Palliative Care, 2007). "To heal is not necessarily to cure. To heal is to bring various levels of oneself-cellular, physical, intrapersonal, interpersonal, societal, spiritual, perhaps even cosmic-into relationship with each other" (Matzo & Sherman, 2010, p. 41).

Those who have not been successful at managing their substance abuse and have chronic disease with no cure, palliative care may be an option. The World Health Organization (WHO) defines palliative care as “an approach that improves the quality of life of patients and families who face life threatening illness by providing pain and symptom relief, and spiritual and psychosocial support from diagnosis to end of life and bereavement” (Matzo & Sherman, 2010, p. 85). It can improve the overall quality of life for both the person with illnesses with no cure and their family (Palliative Care at the End of Life, 2007). Mok and Chiu, (2004) discuss the four major categories and their importance related to the nurse patient relationship when palliative care is provided.

These four categories include; building a relationship of trust, being part of the patient’s family, recharging as the patient and nurse navigate the journey of living and dying and enriched experienced (Mok & Chiu, 2004). Many times a person receiving palliative care will qualify for hospice care as their disease progresses. If a provider feels they have six months or less to live and chose not to seek curative treatment for their illness, they are hospice appropriate. (Hui & DeLa Cruz, 2012).

Hospice originated as a philosophy of care. In the 1960s, Dr. Cicely Sanders is credited for hospice evolving into a discipline that specializes in management of symptoms, spiritual care, psychosocial, decision making and caregiver support at end of life (Hui & DeLa Cruz, 2012).

### **‘Total Pain’**

Hinshaw and Hinshaw (2013) note, end of life care for those who are addicted, can present a level of suffering that can be especially difficult to address. Suffering and the

concept of 'Total Pain' are described as "the state of severe distress associated with events that threaten the intactness of the person" (Hinshaw & Hinshaw, 2013, p. 122).

Providing a guide, that describes frequent symptoms of those dealing with chronic illness and addiction, would provide an enhanced level of understanding about the physical and psychological suffering. This would be beneficial to the veteran, and caregivers with the ultimate goal of higher level of awareness and improved care.

### **Current Project**

The next chapter will discuss the guide and power point developed after gathering the information related to prevalence, physical and psychosocial effects of substance abuse. The information provided in the guide and power point presentation will address both the physical and psychological concerns for those older addicted veterans, near end of life. Special emphasis is placed on care of the older addicted veteran. With an increased level of awareness targeted to the paid caregivers, the goal is symptom management, for all veterans near end of life.

### **Chapter 3: Methods**

For the older addicted veteran, the research demonstrates need for education for paid caregivers related to chronic illnesses and the symptoms that occur frequently at end of life. This guide and power point is intended to increase the knowledge level of paid caregivers for those older veterans who are near end of life. The intent of the guide is placing emphasis on those veterans who continue to abuse drugs and alcohol.

A guide and slide show presentation will be available to new and current employees, who will provide direct care to those veterans who reside in the Community Living Center at a VA in Minnesota. It will provide education on the most common symptoms faced by those with chronic illness, which can be exacerbated by addiction. It will review the common causes, pharmacological, and non-pharmacological interventions for, dyspnea, anxiety, depression, nausea, vomiting and pain. Reinforcing the need for paid caregivers to look for other potential causes, other than the veteran's issues with alcohol and substance abuse.

Information defining palliative care the concept of 'Total Pain' will be part of the handout and presentation. Paid caregivers of the older addicted veteran need information that raises their level of understanding and awareness as to the psychosocial suffering that many addicted suffer.

The presentation will offer information, in simple terms so paid caregivers of all educational levels will have an increased understanding of both physical and psychosocial symptoms the older addicted veterans may need assistance in managing. The need for management of these symptoms may be related to both chronic illness and unsuccessful management of their addiction.

Potential challenges include the ability of current staff to attend formal training related to the volume of mandatory training as part of the requirement for all paid caregivers. New employees at the VA in Minnesota attend 3 weeks of formal orientation, this information could be adapted as part of this training. The drawback is information overload for the new paid caregivers. Also, due to the need for 24 hour nursing care in the Community Living Center, the turnover rate of staff is high in this area. Many employees go on to change to an area in the facility that works Monday through Friday, no weekends or holidays.

Advocating for the training of paid caregivers at this VA, as it relates to management of chronic illnesses and substance abuse cannot be overstated. The paid Community Living Center, at this VA, comprises approximately 350 nurses of various educational levels. This includes Registered and Licensed Practical Nurses and Nursing Assistants. They care for the veteran in a setting that is considered their home, for as long as they reside in the Community Living Center.

The use of a guide and power point presentation make it easier for staff to access the training at a later date when the need arises or when they have time in their schedule to work on educational material. The intent of training is to increase the level of awareness and have this information be retrieved immediately as the care for any veterans experiencing such symptoms. This type of education would empower the nurses by improving their knowledge base and the veteran would be on the receiving end of evidenced based care.

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## **Appendix A: Approaches to Caring for Older Veterans with Chronic Addiction: A Guide for Staff**

The purpose of this guide is to provide awareness training for paid caregivers on how to provide care to older addicted veterans, and manage symptoms associated with chronic disease. It is important to remember not all symptoms in need of managing are directly related to addiction. For some older veterans, being successful in their management of their addiction should no longer be the focus of their care. The focus should be changed to symptom management of their chronic diseases.

Furthermore, the goal of this guide is to increase the level of information on the physical or emotional suffering that may affect the addicted veteran, using the “Total Pain” philosophy and palliative care approach. The ultimate goal is to give paid caregivers the necessary tools to provide high quality holistic care, especially to those veterans at end of life.

### **Definition of Palliative Care**

Palliative care is defined as a form of care with the goal of improving the overall quality of life for both the person with illnesses with no cure and their family. It is important to understand each individual's goals of care, and how best to achieve them.

### **Total Pain Philosophy**

Human suffering is a complex process experienced in four different dimensions: psychological, physical, social and spiritual. Many times the addicted person is attempting to relieve suffering they are experiencing in the psychological dimension.

The following section will review management of some common symptoms associated with chronic disease.

**Common symptoms experienced with chronic conditions:**

- **Dyspnea: shortness of breath**
  - Potential causes: pneumonia, Chronic Obstructive Pulmonary Disease (COPD), Congestive Heart Failure (CHF), kidney disease, cancer, liver failure
  - Medicated interventions: Morphine, bronchodilators, Nitroglycerin, Benzodiazepines (Ativan), oxygen, fluid pills, antibiotics and steroids
  - Non-medicated interventions: Position change, purse lip breathing, application of cool, damp cloths, circulation of cool air, acupressure, acupuncture, essential oils, attempting to identify causes of anxiety.
- **Anxiety: feeling of distress with no known direct cause**
  - Potential causes: Myocardial infarction, pulmonary embolus (blood clot in lung) dementia, infections, uncontrolled pain, withdrawal of alcohol, and other drugs, dealing with life limiting diseases, post-traumatic stress disorder (PTSD), loss of independence, being a burden to loved ones.
  - Medicated interventions: Buspirone, Benzodiazepines (Ativan), Diphenhydramine (Benadryl), antidepressants
  - Non-medicated interventions: Acknowledge fears about possible symptoms, and future care of their disease. Decrease caffeine, alcohol intake, stress management, psychotherapy (counseling), support groups
- **Depression: loss of interest in usual activities for greater than 2 weeks, recurrent thoughts of death, difficulty concentrating, making decisions.**

- Potential causes: Heart disease, cerebrovascular disease, untreated pain diabetes, kidney and liver failure, memory loss, substance abuse, loss of independence, social contacts, and employment, change in financial status and body image, family history, facing life limiting illness
- Medicated interventions: Sertraline, Paroxetine, Venlafaxine, Mirtazapine, Trazadone, Methylphenidate, Fluoxetine
- Non-medicated interventions: Counseling, reminiscence and life review, setting realistic goals
- Nausea and Vomiting
  - Potential causes: Chemotherapy, cancer, Auto Immunodeficiency Syndrome (AIDS), Diabetes, heart, kidney and liver failure.
  - Medicated interventions: Haloperidol (Haldol), Scopolamine, prochlorperazine (Compazine), ondansetron (Zofran), diphenhydramine
  - Non-medicated interventions: Self-hypnosis, imagery, distraction, desensitization
- Pain: whatever the experiencing person says it is, and is occurring whenever the person says it is.
  - Potential causes: Cancer, Diabetes, Surgery, Osteoarthritis, Osteoporosis, Acute Injury, Arthritis, Heart disease, Infections,
  - Medicated interventions: Acetaminophen, Non-Steroidal anti-inflammatories (Ibuprofen, Naproxen), Morphine, Fentanyl, Oxycodone, Hydromorphone, Antidepressants, Antiepileptics, and Topical Analgesics.

- Routes for medications: Oral, Intramuscular, Intravenous, Topical, Intrathecal.

Non-Medicated interventions: Radiation, Massage, Music, Art, Imagery, Pet therapy,

Hypnosis, Acupuncture, Acupressure, Heat, Cold, Vibration, Transcutaneous

Electrical Nerve Stimulation (TENS), Exercise, Distraction, Cognitive and Behavioral

Interventions, Relaxation, Meet with Social Worker, Clergy, Psychologist, Support

Group.

**Appendix B: Approaches to Caring for Older Veterans with Chronic Addictions: A Guide for Staff (power point presentation)**

## Approaches to Caring for Older Veterans with Chronic Addiction: A Guide for Staff

LAURA KUNSTLEBEN

### Purpose of Guide

- **Purpose**

- To provide awareness training for paid caregivers on how to provide care to older addicted veterans, and manage symptoms associated with chronic disease.
- It is important to remember not all symptoms in need of managing are directly related to addiction. For some older veterans, being successful in their management of their addiction should no longer be the focus of their care. The focus should be changed to symptom management of their chronic diseases.

## Purpose of Guide



- **Purpose**

- Furthermore, the goal of this guide is to increase the level of information on the physical or emotional suffering that may affect the addicted veteran, using the “Total Pain” philosophy and palliative care approach. The ultimate goal is give paid caregivers the necessary tools to provide high quality holistic care, especially to those veterans at end of life.

## Definition of Palliative Care



- **Palliative Care**

- Palliative care is defined as a form of care with the goal of improving the overall quality of life for both the person with illnesses with no cure and their family. For paid caregivers, it is important to understand each individuals goals of care, and how best to achieve them.

## Total Pain Philosophy



### **Total Pain Philosophy**

- Human suffering is a complex process experienced in four different dimensions: psychological, physical, social and spiritual.
- Many times the addicted person is attempting to relieve suffering they are experiencing in the psychological dimension.
- The following slides will review management of some common symptoms associated with chronic disease.

## Common Symptoms



### • **Dyspnea (shortness of breath)**

- Potential causes: pneumonia, Chronic Obstructive Pulmonary Disease (COPD), Congestive Heart Failure (CHF), kidney disease, cancer, liver failure
- Medicated interventions: Morphine, bronchodilators, Nitroglycerin, Benzodiazepines (Ativan), oxygen, fluid pills, antibiotics and steroids
- Non-medicated interventions – Position change, purse lip breathing, application of cool, damp cloths, circulation of cool air, acupressure, acupuncture, essential oils, attempting to identify causes of anxiety.

## Common Symptoms



- **Anxiety** (feeling of distress with no known direct cause)
  - Potential causes: Myocardial infarction, pulmonary embolus (blood clot in lung) dementia, infections, uncontrolled pain, withdrawal of alcohol, and other drugs, dealing with life limiting diseases, post traumatic stress disorder (PTSD), loss of independence, being a burden to loved ones
  - Medicated interventions: Buspirone, Benzodiazepines (Ativan), Diphenhydramine (Benadryl), antidepressants
  - Non-medicated interventions: Acknowledge fears about possible symptoms, and future care of their disease. Decrease caffeine, alcohol intake, stress management, psychotherapy (counseling), support groups

## Common Symptoms



- **Depression** (loss of interest in usual activities for greater than 2 weeks, recurrent thoughts of death, difficulty concentrating, making decisions)
  - Potential causes-Heart disease, cerebrovascular disease, untreated pain Diabetes, kidney and liver failure, memory loss, substance abuse, loss of independence, social contacts, and employment, change in financial status and body image, family history, facing life limiting illness

## Common Symptoms



- **Depression-continued**

- Medicated interventions- Sertraline, Paroxetine, Venlafaxine, Mirtazapine, Trazadone, Methylphenidate, Fluoxetine
- Non-medicated interventions- Counseling, reminiscence and life review, setting realistic goals

## Common Symptoms



- **Nausea and Vomiting-**

- Potential causes-Chemotherapy, cancer, Auto Immunodeficiency Syndrome (AIDS), kidney and liver failure.
- Medicated interventions-Haloperidol (Haldol), Scopolamine, prochlorperazine (Compazine), ondansetron (Zofran), diphenhydramine
- Non-medicated interventions-Self-hypnosis, imagery, distraction, desensitization

## Common Symptoms



- **Pain:** whatever the experiencing person says it is, and is occurring whenever the person says it is.
  - Potential causes: Cancer, Diabetes, Surgery, Osteoarthritis, Osteoporosis, acute injury, Arthritis, Heart disease, Infections,
  - Medicated interventions: Acetaminophen, Non-Steroidal anti-inflammatories ( Ibuprofen, Naproxen), Morphine, Fentanyl, Oxycodone, Hydromorphone, Antidepressants, Antiepileptics, Topical Analgesics.
  - Routes for medications: Oral, Intramuscular, Intravenous, Topical, Intrathecal

## Common Symptoms



- **Pain-continued**
  - Non-Medicated interventions: Radiation, Massage, Music, Art, Imagery, Pet therapy, Hypnosis, Acupuncture, Acupressure, Heat, Cold, Vibration, Transcutaneous Electrical Nerve Stimulation (TENS), Exercise, Distraction, Cognitive and Behavioral interventions, Relaxation, Meet with social worker, clergy, psychologist, support group

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