spectra 106

Quality of life in old age

2 **Alcoholism in the ageing**

Every sixteenth person in Switzerland over the age of 60 regularly drinks too much alcohol. Many of them only become addicted to alcohol in old age. They may be unable to cope with the transition from working life to retirement, they may become isolated or, simply out of boredom, treat themselves increasingly to the pleasures of alcohol and other substances. But the declining water content in their body makes elderly people increasingly susceptible to the risk of addiction. Alcohol abuse in the elderly is often "tolerantly" overlooked. But two or three more glasses "for the road" are two or three too many and are far from being a trivial matter.

3 **Palliative care**

"Palliare" is Latin for "to cloak" and "pallium" means "coat". Like a protective, comforting coat, palliative care measures are intended for patients in whom the focus is no longer on recovery, but on alleviation of suffering and quality of life. Palliative care originated in cancer medicine. In view of the growing numbers of elderly and very elderly people suffering from incurable conditions, palliative care is a key approach to treatment in homes for the ageing and care homes. A brochure produced by Curaviva and the Federal Office of Public Health includes touching personal accounts that provide an insight into the theory and practice of palliative care.

4 **Addicts in care homes**

Thanks in no small part to the heroin prescription programmes that are saving addicts from impoverishment and a life on the streets, ever more former drug addicts are reaching an age where they need specialist care in an appropriate institution. "spectra" spoke to Kaspar Zölch, director of the Solina home in the Bernese Oberland, which has been caring for addicts in heroin or methadone substitution programmes, and also for alcoholics, for several years. They live in mixed groups with other residents of different ages and genders. What have the home's experiences been and how do the addicts get on with elderly residents, people in the local village and the home's staff, for example?

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That last "one for the road" can be one too much in the elderly

Alcoholism in ageing. Every sixteenth person in Switzerland over the age of 60 regularly drinks too much alcohol. This problem is often not taken seriously.

The large majority of the elderly in Switzerland confine their alcohol intake to a low-risk occasional glass of red wine or beer. However, 6.4% of this age group exhibit "chronic high-risk alcohol consumption", with about twice as many men being affected as women. "Chronic high-risk" means an average daily intake of more than four (men) and more than two (women) standard alcoholic drinks a day. A standard drink is, for instance, 300 ml of beer or 100 ml of wine.

Stronger effect in the elderly

These limit values of four and two glasses of alcohol a day are undoubtedly harmful to health in all people. But even smaller quantities can be problematic, particularly in the elderly, who are at increased risk of addiction. It is estimated that one elderly alcoholic patient in three only develops their alcohol addiction after retirement. The reasons are partly physiological: the older the body, the less water it contains and the less any alcohol consumed is diluted. The same quantity of alcohol creates a higher alcohol content per millilitre of blood in the elderly than in a young person. This means that what used to be a safe level of alcohol consumption can turn into a problem in old age. Moreover, the efficiency of the liver declines in old age. It takes longer to break down alcohol, which consequently stays longer in the body.

Retirement – a critical life phase

But there are also psychological and social reasons for the increased risk of addiction in the elderly. For some, retirement is a time of indulgence: the pressures of working life are gone, they have more leisure time, more extra treats in everyday life – an aperitif before dinner, a glass of wine with their meal and a drop of spirits afterwards. For others, retirement is a time of emptiness and loneliness: the end of their working lives also means the loss of their daily routine, bearings and social life. In addition, the loss of people close to them – their life partner, siblings, friends – becomes an increasingly familiar experience in this phase of their lives. In all these cases, alcohol has its attractions and its perils. The occasional drink can grow into two, three or four – and it can become more than occasional.

No trivial matter

Alcoholism in the elderly is usually a silent addiction. Most of those directly affected do not want to admit it to themselves – they are ashamed or they consider the idea absurd that they themselves are addicted. People close to them often play down their alcohol problem and are unwilling to deny their old friend "one (or two or three more) for the road". This approach does not do them any favours: alcohol dependence impairs quality of life in old age just as much as it does in younger people, quite apart from the increased risk of diseases such as diabetes, dementia or cancer that long-term, excessive alcohol intake causes in the elderly. Moreover, alcohol consumption not only has negative effects on health, it also increases the frequency of accidents in the home, during leisure activities and in road traffic.

Discussing changes in behaviour

But how do we recognise alcohol addiction in an elderly person? Besides an increase in accidents, the symptoms of alcohol addiction include apathy, withdrawal, belligerence, restlessness and even weight loss. All these symptoms resemble those of the common illnesses of old age and are therefore usually misinterpreted – even doctors often overlook the possibility of addiction.
For this reason, relatives and friends in particular have an important part to play in identifying problems with alcohol at an early stage. If there is suspicion of addiction in an elderly person, experts recommend tactfully raising the subject of their alcohol intake and the changes observed in their behaviour with them. Questions tend to be more productive than accusations, preaching or arguments. Specialist units also offer relatives assistance and advice on how to deal with alcohol-dependent senior citizens.

Interaction with medicines

Alcohol-related illnesses in advanced age are often aggravated by the medicines that elderly patients typically need to take, for instance antidepressants, sleep-inducing agents, tranquillisers and analgesics. The effects of many of these medicines are strengthened by the presence of alcohol in the blood. Others, in contrast, are broken down more rapidly by alcohol and therefore lose some of their desired effect, which means that the dosage has to be constantly raised. This, in turn, increases the risk of addiction to prescription drugs – a risk that is already relatively high in the elderly.

Good prospects of cure

Alcohol addiction is particularly worthwhile combating in old age. Experience shows that measures taken in the elderly have a very good chance of success. This is particularly true if their alcohol problem has developed late in life. Abstinence can, but does not have to be, a goal of treatment. And there is often no need for long drawn-out therapies – just a few discussions aimed at bringing the cause of the drinking to light may suffice.

Structure, friends, hobbies

There is, however, this to bear in mind: growing old does not mean a life of self-denial. But to ensure that alcohol consumption is kept at a moderate level, it is important in old age to give everyday life a purposeful structure. A good social network, family and hobbies constitute the most effective way to prevent alcoholism in the elderly. A glass of wine or a small beer can then continue to be a well-earned indulgence.

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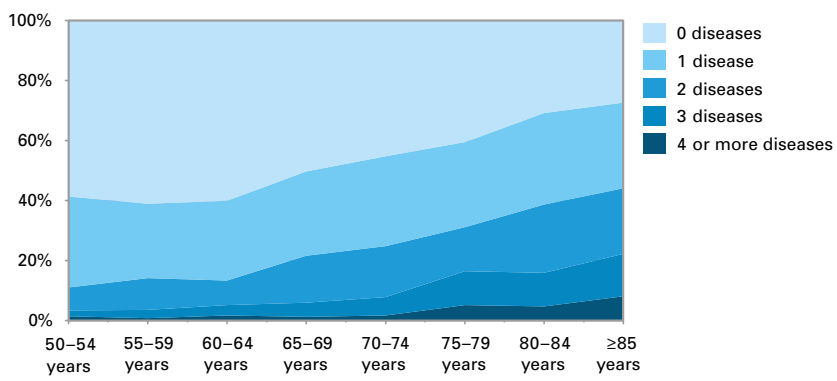
Infograph

Number of chronic diseases broken down according to age group
persons aged 50 or over, N=3627



Source: SHARE 2010–2011, evaluation by Obsan

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"No longer exhaust every practical possibility, but focus on the patient's peace of mind"

Palliative care/publication. The term "palliative care" is used when the focus of treatment is no longer on cure or life-prolonging measures, but on alleviation of suffering and on the patient's quality of life. Palliative care is playing an increasingly important role in care of the ageing. A brochure is available that provides a touching portrait of this approach in practice, with sensitive contributions from patients and health professionals.

"It's all about relieving the patient's suffering. It's important to talk with everyone concerned. Talk, talk and talk again. And it's important to make generous use of morphine in the terminal phase." This is how Balz Briner, GP at the "Am Wasserturm" home for the elderly in Basel, views palliative care. Briner features prominently in the brochure "Menschen am Lebensende begleiten" (Supporting people at the end of their lives), published by the Curaviva association of Swiss care homes and the Federal Office of Public Health. The authors Cornelia Kazis (German version) and Anne-Marie Nicole (French version) give a precise and touching account of palliative care through portraits and reports concerning people who directly experience this approach in a care facility for the elderly. The resulting stories describes what is in people's minds as their life moves towards its close. And they show how patients are treated and looked after in accordance with the basic principles of palliative care.

Integrated treatment

As adapted from the WHO definition, palliative care is "the active, integrated treatment of patients with a progressive, advanced disease and limited life expectancy at a time when the disease no longer responds to curative treatment and top priority is given to the management of pain, other symptoms and psychological, social and spiritual problems". What this can, and does, mean in actual practice is vividly described in the brochure through stories from the everyday care of elderly patients. Contributions come from a wide range of different people – for instance, two care home residents, Frau Schwab and Madame Lutz. But the authors also shadowed the professionals at their work of treating and caring for the patients – nurses, the director, pastors, GPs and voluntary workers. And even people such as Nghia Thai, who works in the kitchen, or Ornella Francolini, whose mother is a resident, tell their stories in the brochure. They are all able to help make the final stage in the patients' lives as agreeable as possible and to alleviate their suffering as much as possible. That is the essence of palliative care. "Palliative" stems from the Latin verb *palliare*, "to cloak", and *pallium*, "coat". As such, palliative care also means that personal wishes and preferences with regard to food and drink, for instance, or, in the context of care, the patient's life history, are taken into account.

Increasingly important in care of the ageing

Palliative care has its origins in cancer medicine. But the demographic development has been such that it now plays a key role particularly in care of the ageing. Growing numbers of people now live to an advanced or very advanced age, with all the associated infirmities, disturbances and diseases. In these patients, cure is no longer the goal. In care homes for the elderly, the high-tech equipment of acute care is relegated to the background. According to Balz Briner, it is "an opportunity to no longer exhaust every practical possibility, but focus on the peace of mind of the elderly people who live here". It is therefore all the more important for nursing homes and the general public to be familiar with the possibilities of palliative care. The new brochure is an introduction to this approach that is not only informative but also inspiring and touching.

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Free Download

The brochure "Menschen am Lebensende begleiten. Geschichten zu Palliative Care in Alters- und Pflegeinstitutionen" [Supporting people at the end of their lives. Stories about palliative care in homes and services for the ageing] is available in a German and a French version. Download at: www.bag.admin.ch/palliativecare or www.curaviva.ch/dossiers > Palliative Care.

Printed version available free of charge at www.bundespublikationen.admin.ch (Article no. 316.723).

At first hand

The French general and statesman Charles de Gaulle once said: "Old age is a shipwreck". This comparison accurately illustrates what people long thought about old age. In earlier times life was often no more than a fragment, people regularly died young. But those who lived to an advanced age often experienced it as an affliction, once the work and family that had given meaning to their lives were gone and physical ailments and loneliness increasingly set in.

Life expectancy in Europe has more than doubled in the last two hundred years. These extra years are a gift to us, a new and hitherto unknown window of opportunity. Many people make active use of it, continuing to work full- or part-time, discovering new talents or skills in themselves, travelling, engaging in sport or helping to bring up their grandchildren. This third age, free as it is from many of the pressures of everyday life, also enables us to reflect on our own lives and, just as importantly, develop a new understanding of the world around us. The collective memory, the awareness of where we have come from, takes on a new quality because children no longer experience only their parents, but often two sets of grandparents and sometimes even great-grandparents.

However, the ageing of society also has disadvantages. They include the acute shortage of care facilities for the elderly, soaring healthcare costs and the increase in non-communicable diseases such as cancer, diabetes and cardiovascular, chronic respiratory and musculoskeletal diseases. For many people, old age is also associated with financial pressures, loneliness and depression.

When it comes to life expectancy, we in the industrialised countries are world leaders. However, this top ranking also obliges us to decide what purpose we want to give our increasing longevity and how we want to spend the third phase of our lives. It is my firm conviction that we need to create an awareness that a healthy lifestyle translates into quality and enjoyment of life. We also need to understand that it is largely responsible for making us physically, mentally and spiritually fit and healthy enough to live our lives and particularly our old age. We can all of us help ensure that the years we are "gifted" are actually experienced as a gift – and not as a shipwreck.

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"We don't judge whether the lifestyle they choose is good or not."

Interview with Kaspar Zölch. What happens with addicts once they reach an age at which they are dependent on care and support in residential facilities? The care homes and homes for the elderly that accept them are still few in number. The Solina Spiez in the Bernese Oberland accommodates 180 persons in need of care. Ten of them are former drug addicts now receiving methadone or Diaphin (the pharmaceutical proprietary name for pure heroin) in the framework of a substitution programme, and 25 are alcoholics. Solina Spiez director Kaspar Zölch talks about his experiences with his colourful mix of clients and their very specific needs.

Kaspar Zölch

spectra: Mr Zölch, what's special about your facility?

Kaspar Zölch: We look after 180 residents aged from 18 to 104, a third of whom are under 65. They're all seriously or very seriously in need of care – we score about 8.2 out of a possible 12 points on the care-level scale. Besides elderly residents and people with dementia, they include younger multiply disabled or cancer patients without any medical perspectives, and persons who are referred to us from psychiatric facilities. To some extent, our residents reflect society as it exists in the outside world. We focus primarily on the question: what do people bring with them when they come to the Solina? Each and every one of them has resources. These provide the basis for life in our facility.

Everything is mixed in our departments. We don't have any disease-specific dedicated units for dementia, multiple sclerosis or hemiplegia. We are committed to mixing our residents. There are nine people in a residential group. They're assigned in accordance with the available resources, independently of age and gender or whether somebody comes to us with a dependence problem. We've been implementing this philosophy for about seven years, and the results are good.

Most of our residents have restricted mobility – very many of them use wheelchairs. The focus is on their wellbeing. Applying care, medical and social therapy measures, how can we guarantee each and every one of them a sense of wellbeing in this phase of their lives? It all centres around key issues such as self-determination, freedom from pain and zest for life.

You've also been looking after addicts here for the last ten or so years.

Yes, many of them come here from the heroin prescription programmes in Berne, Burgdorf, Biel and Thun. Or from hospitals in which they have landed after, for instance, an accident. The youngest former drug addict is 38, the oldest 58. Time spent living on the streets shortens life expectancy massively. Most suffer from a huge underlying psychiatric disorder on which they have then – to some extent as self-therapy – planted their addictive behaviour. About three quarters of them are men, one quarter women. They're all chronically ill, and the focus is on their wellbeing. Guiding them towards abstinence is not our main goal. We don't judge whether the lifestyle they choose is good or not. If someone wants to reduce their substance use, we naturally provide them with support.

What differences are there between alcoholics and opiate addicts?

Alcoholics are harder to manage than residents undergoing substitution treatment. With Diaphin-substituted patients we have the option of imposing sanctions. Anyone whose breath test shows they have too much alcohol in their blood is given methadone in place of Diaphin, which they do not appreciate at all. In fact, this aversion to methadone is so strong that people would rather miss out on the home's seaside holidays than Diaphin. That's because we're not allowed to take Diaphin over the border.

How did the staff react when you began taking in dependent drug users?

At the outset, there were considerable concerns. Many of the staff were opposed, believing that such people did not belong here. They were afraid that medicines would be stolen or used for dealing, and they couldn't imagine carrying an alcohol testing device on the medicine trolleys and having patients on substitution therapy blow into it before the medicine is dispensed. Today, caring for Diaphin patients is very straightforward – it's an illness like any other.

As a rule, residents have to administer their intravenous dose themselves. It's too much to ask of the care staff that they search for a suitable injection site in veins hardened by years of intravenous abuse.

How do you deal with alcoholics?

The consumption of alcohol is permitted in Switzerland provided we behave properly and have enough money to purchase it. In this country we can drink like a judge and smoke like a chimney – it's just the way it is – and it's basically the same in a long-term care facility. What's crucial is the limit with regard to the medicines being taken – particularly in the case of patients on substitution treatment. Depending on the circumstances, we look for appropriate measures: limiting the amount drunk, controlling patients' intake via their spending money. We also sometimes try to regulate alcohol intake: one beer in the morning, one at noon, one in the evening and one for the night. This works well in some cases, and the patients no longer have the stress of procuring the alcohol.

It's more of a problem when, because of their previous drinking habits, someone is no longer able to make decisions for themselves and their behaviour is becoming a huge threat to their health. In such cases, alcohol consumption should actually be prohibited. But who decides whether someone is still capable of making decisions for themselves? Many don't want to live in abstinence, even though it's the only way of ensuring their survival. This can sometimes lead to highly sensitive conflicts.

How are such problems solved?

We regularly organise "round tables" with the residents concerned, family members (if any can still be found), carers and support staff, legal guardian/representative, social services and sometimes the pastor. The discussions can become very heated. How does the person involved want to lead their life and what is needed to assure their personal wellbeing? If someone consciously wants to spend their lives three sheets to the wind, they are allowed to do so – we are not a moral authority and have no educational mandate.

What kind of daily structure do you offer residents?

There's a very low-threshold set of activities in the creative workshop. We work there with residents on a very individual basis and they can also earn a little pocket money. In addition, we have a number of therapy groups – painting, cooking, men's and women's groups, etc. A certain structure is also created by having residents carry out everyday tasks such as setting and clearing the tables, tidying their own rooms, making their own beds and taking part in small personal hygiene training groups.

How are the former dependent drug users regarded here in Spiez? How do they get on with the other residents of the home?

Relatives sometimes have a problem with the fact that their grandmother's room is right next door to someone with a history of drug-taking. But when they come for a visit and see for themselves how the residents get on together in everyday life, their prejudices are usually dispelled.

In the village, we're accepted up to a certain point. There's nothing we can do about it if residents set off with their walking frames to Aldi, Coop or Landi to buy five or ten cans of beer at 50 centimes each – they can scarcely afford more than that on their maximum of ten francs a day pocket money (which may also have to stretch to cigarettes). Some of them try begging. This causes bad feeling and talk in the village. People ask why 60 million francs are being spent on building a home for "people like that"?

How do the residents get on living together?

There are few problems among the residents. With dementia patients in particular, other people's past histories are irrelevant. What is crucial for them is whether they're respected as human beings. There are certain rules of etiquette that have to apply to everyone. Elderly people of more refined habits sometimes have greater problems with living together. Having to share bedrooms is certainly a problem, but this will be resolved when the new building has been completed: then we'll have single rooms only.

Drug-related crime and drug dealing feature prominently in life on the streets. Have you also got to address these issues?

Some things cannot be prevented if we allow certain freedoms and let everyone lead – within the limits of the law – the kind of life they want. We intervene in cases of illegal drug use that go beyond personal needs, and we draw a line at repeat offences. But those concerned already know this.

Smoking hash is also an issue. Cannabis is basically not tolerated, but we don't police the home. Smoking is in any case not allowed on the premises, except on balconies and in the designated smoking room. Those who smoke in the open air do so at their own risk. If drugs are left lying around for all to see, they are confiscated by the staff. But cannabis is also used officially: some residents, particularly those with cerebral palsy, receive hemp drops for medical reasons.