

Special Topic

working with long term users of mood altering substances

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I work with “Hard to House” and “Hard to Handle” clients (people who are often long term users of mood altering substances) in Vancouver, British Columbia’s Downtown East Side (DTES). Our community is not unique. People who are long term users of mood altering substances can also be found in many other low income communities in Canada and the United States. Now older, they were the alienated and disenfranchised youth of a bygone era.

The people that I work with have lost everything. Now they pay the ultimate price of their addiction: a humiliating loss of dignity. It is important to realize that these are people who have fallen through the social safety net. Previous attempts to help them have failed, or only worked in the short term.

As a counsellor and a support to them, it is essential for me to be aware of the high emotional and psychological cost that our society has demanded from these people long before I see them. No other social and health condition is as heavily laden with societal stigmas as addiction is. Even within the addiction community, the language used for long term users and the attitudes towards them is brutal and punishing. They are often described as “non-compliant”, “frequent flyers”, “resistant”, “unmotivated”, and “bed-blockers”. We blame them for failing to meet our needs and expectations. We would never consider treating people with other health conditions (e.g., cancer patients) the same way that we treat people who abuse mood-altering chemicals.

A Starting Point

Substance use must be understood as an essential and integral part of the person. It is not a pathological part that can be treated outside of the whole person and removed. The dependency is a part of the person’s identity, attached to the individual’s core belief structures. In many cases, it is the most comforting and consoling relationship that the person has in an otherwise bleak and lonely existence.

Recognizing this, the counsellor who is working with long time users must be able to provide a relationship that brings an equal amount of comfort and consoling. Long time users are people whose lives are filled with poverty, despair, and alienation. More often than not, they must deal daily with the loss of significance, meaning and purpose in their lives, along with all their dreams and loved ones. Self medication by alcohol or drug use is often the only escape from this emotional pain that they know works, even if only temporarily.

All too often the addictions counsellor paternalistically and patronizingly tells the clients what is best for them, without having a meaningful relationship. No wonder the counsellor is often viewed as yet another outsider, conspiring with other “do-gooders” who want to take away the only thing that relieves the pain that the person is feeling.

Too often, we want them to change, based upon social beliefs that come from a society that they are alienated and disenfranchised from, a society that has failed them. Substance abusers are a barometer of the health of our society; they act out the alienation and despair felt by us all and they are the best indicators of a society’s social and spiritual health.

Most of the people I have worked with were abused as children. This important issue has gone untreated throughout their adult lives, and they are

trying to cope as best they can. They typically have lived with trauma piled upon trauma, with all of the associated pain that comes with the traumas. Substance misuse is a symptom of their distress and pain.

Many long term users seem to age faster and die sooner than other adults. They may have health problems that are more typical of people who are 15 to 20 years their senior than people their own age.

A Model for Working Better with People Who are Long Term Users

The basis of this model is to establish a relationship with the person, and help restore respect, meaning, and dignity to the person's life. These elements are often the last three significant losses that people have experienced on their way to the Downtown East Side.

The traditional clinical approach emphasizes detachment and professional boundaries. That approach does not work here. Long term users are people who need to see that there is genuine care and concern for them. They need to know that you see them as persons, not just another client on your caseload. They need to know they are not a project with short-term goals and objectives that satisfy the needs or good intentions of the counsellor or an organization. Instead, they need to know that they are recognized as persons who are isolated and alone, struggling with an addiction through no fault of their own.

The key to working with people who are long term users and who are living in marginal conditions, is taking the time and effort to develop a genuine relationship that authenticates their value as people. Addictions counsellors or other support persons working here must really like the people they work with and have real empathy for all the losses the people have suffered as a result of their addiction. In other words, the counsellor must become a friend and be willing to take the same emotional risks that they are asking the client to take. An unequal relationship will not work here. The counsellor must make an equal emotional investment, and become willing to work and grieve alongside the client.

The counsellor must expect and anticipate transference and projection from the person. By "transference", I mean that the person is likely to carry feelings and reactions from the past and characterize the present relationship with the counsellor in the same way ("Everybody has abandoned/ used me, so you'll probably abandon/ use me too"). "Projection" refers to the process where a person projects her or his own emotions or beliefs on to the other person ("I hate myself, you must hate me too").

People carrying as much pain as these clients are, will often lash out: the counsellor's role is to understand the feeling and identify it for them. While a counsellor may prefer to be emotionally detached, it won't work here. For the counsellor and client, the emotional cost of detachment (not having a trusting relationship) is far higher than any potential harm from attachment. This detachment is often expressed as irritation towards one's clients and can lead to a form of burnout (psychic numbing) and depression. Attempts by counsellors to protect themselves from the client's emotions will leave the counsellors feeling psychically numb and it will negatively affect every area of the counsellor's life. A counsellor cannot be detached all day and then magically become attached at home.

Features of the Model

When supporting long term users who live in marginalized communities like the Downtown Eastside, the relationship and trust building begins at the first contact ("Intake"). The therapeutic outcome (or degree of "success") will reflect the degree of relationship established by the counsellor. Take the needed time; the person is definitely worth the effort at any age. There are several approaches that improve the chances of positive change:

1. Meet needs.

Begin by ensuring that the person's basic needs are being met. This includes stable housing, nutrition and other basic personal needs.

2. Use an outreach model.

Visit the person in his or her residence. Many will be unable to keep appointments, and may

not have the mobility or the means to travel to you. Short daily drop in sessions are useful in the beginning; don't overstay your welcome. Build a relationship on their terms slowly; trust is a big issue for them.

3. Take a whole person approach.

Get to know the person and their health, psychological and social situation. Slowly over a period of time, determine the person's current medical conditions and medications. Get a good sense of the person's level and type of substance use/misuse, and the things that increase or decrease that use over time. Also identify resentments, losses (sources of emotional pain) and fears that the person may have. Going in and asking questions "right off the bat" is not likely to work.

4. Assess status, strengths and barriers.

Listen, ask the right questions and non-judgmentally observe. Assess where the person currently is physically, emotionally and in terms of motivation. This may involve using age-appropriate screening tools such as the

- a. CAGE (a basic screening tool to assess if there is or has been an alcohol problem);
- b. Geriatric version of the Michigan Alcohol Screening Test (G-MAST);
- c. Drug Abuse Screening Test (DAST);
- d. Motivational Stage of Change; and
- e. Global assessment of functioning (GAF), Axis V of the DSM-IV.

Counsellors who are very familiar with these assessment tools find that they can easily "slip in" many of the questions as a part of ordinary conversation.

A proper assessment can easily take six hours. It cannot be done all at once. Instead, plan on using the first six visits to get to know the person, using gentle probing questions, more listening than talking, and observing. For example, consider asking "Have you been able to eat today?" "Oh, what did you have for breakfast?" or "When was the last time you had a drink." Your level of ease with the questions you ask will often affect the type of response you get.

5. Identify any trauma or grief issues.

It is also important to do a trauma and grief assessment, exploring specific kinds of trauma and losses that the person has experienced (and usually there are multiple traumas). Has the person experienced recent or past losses, and if so what kind and how have these affected the person?

Trauma assessment can be done through a review of life history (e.g., asking the person to talk about his or her past: remembering a father or step father who beat him; family members who died by accident, suicide or murder; or abuse issues). It is important to understand where the person is in terms of dealing with the trauma. Assess the person's stage of grief.

6. Screen and identify whether there are any co-occurring disorders.

This can help the counsellor better understand "What is causing what I am seeing?" This screening includes considering the person's emotional level (affect), appearance (is the person neglecting his or her health, or living environment), and whether the person is anxious.

Are there any behavior, cognition (memory, thinking or planning) or dissociation problems? For example, does the person distract himself or herself from feeling (look away at the floor), respond with frozen feelings (red eyes, watering)? Dissociation problems may be trauma-related. Does the person dissociate from consequences, or fail to accept responsibility for events? (e.g., "My wife left me, she's just a hag").

Use the Mini Mental Status Exam (MMSE) **when appropriate**. This occurs when the person's mental competency is in question (e.g., where the person is drinking herself or himself to death). People generally know the questions used in this test (e.g., the test requires people to spell the word "WORLD" backwards) mean they are being tested. Some are concerned that they might fail. Recognize that lower education level and other factors can negatively affect the results of the test (i.e., give a false reading of incapability).

The counsellor will need a good feel for the person's level of mental competency in order to consult effectively with geriatric assessment services. Geriatric services will want to know the person's MMSE level, for context, to gauge risks and to identify the need for further assessment.

7. Treat co-occurring disorders simultaneously.

Depression, anxiety, mood and personality disorders can all be treated simultaneously with medications and counselling interventions. Some types of antidepressants (e.g., SSRIs) can be safely administered while the person is still drinking.

8. Use treatment planning that is client centered, but agency integrated.

It is very common to find that marginalized people are simply expected to “cycle through” a program. This refers to having to do the things expected by the program at the identified time, and according to its required pace, (“They say ‘you must do this by this time’.”). This approach assumes that the person is ready and able to make the necessary changes. In most cases, this approach will not work for these clients and is likely to set the person up for failure.

A proven, more effective approach is to work “where they are at” (client-centred). In addictions, it is generally recognized that different kinds of strategies are needed based on whether the person is “pre-contemplative”, “contemplative”, or is an “action stage”. If the person is not ready to stop drinking, implying that he or she should stop is often likely to lead the person to dig in his or her heels and not become open to change. “Denial” occurs when the counsellor is telling the client something he/she isn’t ready to hear. The counsellor needs positive ways to deal with resistance and the ambivalence towards drinking or using that the person often feels.

The person must be included in every step of treatment planning and must feel empowered from the beginning of the process.

Consider Ned.

He’s in his late 60s. He receives his pension once a month. He used to go drinking with his buddies at the bars, but has been mugged several times coming home. Now he arranges for a prostitute to drink with him and she picks up a 40 ounce for them. More likely than not Ned will be ripped off before the night is through.

Ned faces multiple harms from this situation. These include sexually transmitted diseases; physical assault and financial abuse; and possibly eviction. There are several different strategies to address the issue, including exploring important issues with Ned, such as why does he pick up a prostitute? Is he lonely for female companionship? With his health problems, is Ned able to have sex? (Impotence is common at high levels of drinking.) If his objective is sex, does he have condoms in his room?

Does he simply want to drink with buddies (i.e., wants to socialize and drink safely), but does not know how to get home without getting robbed? What is the safest way to accomplish that? Are there safer people for Ned to drink with?

Creative strategies might involve finding a closer bar, or safer bar. It could involve looking at what Ned drinks (e.g., Does he become inebriated much faster when he consumes shots of whiskey? Would beer last longer and be safer for him?). It might involve personal changes, such as drinking in his room with his buddies, and having the manager of the SRO residence support that. It might involve advocating for other changes such as opening the residence’s pool room on Fridays so that they can get together without necessarily drinking.

9. Work together and use treatment planning that is agency integrated.

Work in conjunction with health care and other service providers (doctors, nurses, social workers, housing agencies, home support services, mental health services and legal services) and work in a coordinated way to achieve the client's improved quality of life. It is important to have a similar understanding of the client's needs, wishes, and goals in order to work together to help meet those aims and not generate resistance in the client. Build on each others' knowledge and skills (e.g., working with a physician who recognizes that depression can be safely treated while the person is drinking).

Work well with others. Other agencies need to be aware of the client's wishes and be willing to work cooperatively towards the client's goals. Even if you or the other agency personnel feel the client's plan is not the best plan, a client can and does learn from these experiences.

10. Recognize positive changes.

For example, if a person is able to switch from a non-potable type of alcohol (mouthwash) to a type of alcohol that is meant for drinking (wine), that is a positive change and is likely to lead to improvements in the person's health.

If a person is able to gradually taper from drinking 40 ounces of whiskey in a day, to consuming a mickey (12 ounces) every two days, that is a positive change, especially if he is no longer fighting with others or is no longer at risk of being evicted. Recognize progress made, whether or not you personally feel abstinence would be even better for that person.

11. Use multi level harm reduction strategies.

These are strategies that address the lifestyle issues as well as the direct consequences of substance misuse. Most effective approaches are those that address medical/health issues, the social, psychological and spiritual issues simultaneously.

12. Use appropriate planned detoxification.

The need for help with withdrawal is common among long term users and the need arises in several different ways. A person who is a long term user may need a medical emergency detox if he or she hasn't eaten in three weeks, has run out of money for alcohol, is vomiting and quickly going into withdrawal.

In some cases, an acute medical detoxification is life saving. The person is so ill he wants to go to detox services, because he can't even keep the liquor down. In other situations, the person is in the "action" stage of change. The person wants to get sober and stay sober, but needs to detoxify first because he or she is still drinking. Here, an effective approach is to use "tapering": work with the person to cut his or her alcohol intake by about 10% a day. Be sure to not cut back too quickly to avoid seizures.

Older adults need a longer detoxification process because of the greater likelihood of underlying health problems, higher risk of unsafe increase in blood pressure, and multiple past withdrawals. Consider alternative detoxification options, as frail older people may not feel comfortable or safe in traditional detoxification facilities where most of the clients are younger, use street drugs, and may seem intimidating.

Detoxification for the long term user can occur either by means of home detoxification or in a facility, both of which should be medically supervised. A person who lives in supportive housing may be able to detoxify at home, particularly if it is a stable environment and the housing operators are supportive of the process. Medical supervision of the withdrawal by an addiction specialist is imperative for those with complex medical histories.

13. Recognize that the best approach may be one to one counselling.

Group support may or may not be possible for long term users (but see below). Empathic cognitive and motivational interviewing strategies work well, especially when combined with an educational component around the specific harms of their substance misuse. Provide the person with age appropriate information and tie it to the specific health conditions and other issues that the person is dealing with. Generic information is not sufficient.

a. Distorted thinking: Because of the social environment in which they live, marginalized long term user can easily developed distorted thinking patterns. You will need to deal with the cognitive distortions. For example, if the person does not trust anybody, you can help the person look at whether some of his or her choices may be the source of the problem.

Deep and strongly held negative thoughts such as “all people can’t be trusted”, or “all prostitutes are thieves” can easily occur in a neighbourhood where victimization is common. Part of counselling may mean helping the person to look at how he or she frames things. Is it really that “all women are thieves”? Or is it that particular women or men that the person has associated with (e.g., prostitutes who are desperately looking for money for their own substance use problems) are likely to rob.

b. Look at the person’s readiness to change. Help them to consider “where they are at” and how the behaviour is contributing to negative consequences in their lives. Deal with conflicting feelings around change - “If I quit drinking I’ll be lonely. I want to quit. I need ways to not be lonely.”

c. Identify using triggers and patterns. When do they drink? What are the feelings that precede drinking? What are the thoughts that accompany or precede the feelings?

d. Respond to the person’s thoughts, feelings and drinking behaviors concurrently.

e. Group support. Some people who have been loners or socially isolated for long periods of time may not want to try group support, ever. For example, many long term users who were loggers and construction workers may relate better to television than to people. They may not be able to deal with their own or other people’s emotions in a group setting. In most cases, group support may not be appropriate until a firm relationship with the counsellor has been achieved.

14. Use social reintegration strategies.

Most people with long term alcohol problems who live in marginalized areas will socialize at the bar. As a result, when they try to decrease or stop their substance use, they struggle with a lack of ways to connect with people and have meaningful things to do. It is important to find out any other interests the person has had in the past (things or activities that he or she may have given up), such as chess or electronics. Help the person discover ways to rekindle one or more of those interests, such as becoming involved with a chess group at a local centre.

Recognize and help address some of the other barriers to reintegration. A person may need a new wardrobe from the thrift store before feeling his clothes are “good enough” to go the Christmas party, or attend the local senior centre. Or, the person may need help applying for a bus pass to get around.

The person needs to be able to socialize with others in meaningful ways, yet not necessarily have to “do the warm fuzzy stuff.” Some clients may like to be around people, but “on the sidelines”. The objective is to work towards ending the person’s isolation. This may include encouraging clients to participate in groups, or reconnect with past friends and family who are open to renewed contact.

Once the person trusts a counsellor, the person may be more willing to go to a group with the counsellor, but usually not alone. It is important that counsellor continue to support the person (e.g., by staying with them during the group), or feelings of abandonment will likely occur.

15. Some people may need residential treatment.

Residential treatment refers to a safe environment where there is the opportunity for people to be supported over a longer period of time to address the emotional and psychological aspects of why they drink or use other mood altering substances. They are away from their "home environment."

Ideally when older long term users in marginalized communities receive residential treatment, it should be at least three months long and should be low threshold and low intensity ("Take it easy and go slow"). Traditional approaches providing 28 days of residential treatment tend to be too intense, especially if there is a "cycle mentality" (e.g., "you need to have done Step 5 in 28 days"). Residential treatment for older long term users will tend to need more one on one support and counselling, rather than group approaches.

The more effective residential treatment centres will recognize and address the reality that the long term user has been subjected to a high degree of stigma and shame. Women, in particular, are overburdened with sexual shame and guilt.

Throughout residential treatment, there is a need for the counsellor or other support person to follow the client all the way through. This may involve phoning, staying connected, maintaining the relationship and continuity of care, as well as talking with the client's residential treatment counsellor. Sometimes the outreach counsellor can help smooth things over so the client is not as resistant to what is being proposed by the residential treatment staff. After residential treatment, there is a need for long term follow up immediately after discharge, with continued contact, at a lower intensity for another year after that.

16. Work on relapse prevention.

Relapses are very common among long term users. Help the client identify "trigger events". For example, having money on cheque day is a very positive feeling for many people. The person may want to amplify that positive feeling, and celebrate. Working with the person may involve looking at other ways of maintaining the positive feeling without drinking, or less destructively celebrating.

Christmas is often a relapse trigger where the person wants to celebrate ("A couple of glasses of whisky would be nice"). Or conversely, Christmas time may produce very bad memories that the person would like to drown.

A counsellor or other support person can help the client understand his or her feelings, talk through those feelings, and plan ways of dealing with them. Anniversary dates are important to identify and establish early on (e.g., April 17th as the date of the car crash when a son died). Be there for the person that week before the anniversary date, and on the date.

Relapse prevention begins with the first meeting with the client. The client must be apart of the educational, behavioral and cognitive strategies throughout the counselling. "What to do if..." strategies will become an essential part of the recovery process. If relapse occurs, it is not a "failure". Instead, it can be used an opportunity to refine and develop alternative strategies. Relapses must never be judged, they are a vital part of the process and can be used to the person's advantage.

17. Equalize and balance the relationship.

The person may become dependent on the counsellor in the initial phase of the relationship, because in effect the counsellor becomes their best friend, or only friend. The person is investing in the relationship, telling you about things they may have never told anyone. Even if you only see them one hour a week, recognize the fragility of the relationship.

This inequality, if maintained, is unhealthy for the client and the counsellor. Relationships must be balanced, equal and non-hierarchical. By non-hierarchical, I mean, a counsellor should not come across as the expert or a superior person, or one with all the knowledge or power. The person has an incredible wealth of knowledge about himself or herself, the social environment, and brings many skills and strengths to the situation. Draw on that knowledge and skill.

An equalized relationship also means that there can be appropriate forms of disclosure, to help the person understand his or her feelings (e.g., "Yes, Joe, that is painful. I remember when I went through my divorce, I felt... that happened to me, I felt this way...")

The client must come to see his or her worth by recognizing it in this relationship with you. It can be helpful for the clients to see they are having a relationship with a sober person who finds value in them. Again, coming full circle, it must be clear to them that they are not just a client on a caseload, that you are not simply paid to see them, but that you genuinely care and are concerned.

18. Wean dependency on the counsellor. Replace it with connection to peers.

Eventually, a gentle reduction in time spent with the client is needed. Other forms of support or activity must compensate for this change in your involvement, or a relapse is probable. Help the person take what he or she has learned from relationship skills built with you to others, whether that is a chess club, AA group, or other setting.

19. Maintenance of the relationship (long-term).

Wean the person off the relationship very slowly, and only when he or she has replacements and relationship building skills in place. A weekly check-in by the counsellor may prevent feelings of abandonment or the client feeling used (i.e., he or she was just another case on your caseload, or that this relationship was just a sham). This check-in can be a ten-minute drop in for tea or a phone call.

Resources

Connors, G., Donovan, D., DiClemente, C., (2002). *Substance Abuse Treatment and the Stages of Change*. New York: Guilford Press.

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