

# Caregiver's

## HOME COMPANION

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H E L P I N G T H O S E W H O H E L P O T H E R S

## Law Enforcement's Newest Beat: Our Elderly

A Very Different Kind of Policing Helps Keep Alzheimer's Patients Safe



By Sharon Palmer

**W**hen a Washington, D.C., police officer pulled over an 82-year-old man who was driving erratically, the officer found a coherent, angry driver who challenged him to either arrest him or leave him alone. The police officer decided to choose the latter option. Later that evening, the driver, who suffered from Alzheimer's disease and had wandered from home, was reported missing. Almost eight hours after the traffic stop, the missing man was traveling on Interstate 95 when his car swerved into the median and struck two tractor-trailers, resulting in his death.

Cases like this have prompted police departments across the country to bone up on Alzheimer's disease and dementia in order to better serve the public. Police have reported a spike in the number of Alzheimer's cases in which individuals become lost, confused, or refuse help.

With an estimated 4.5 million Americans suffering from Alzheimer's disease, a number that has doubled since 1980, law enforcement has had to face the fact that dealing with this debilitating disease will become part of their daily routine. These days, it's a rare police officer

who hasn't had to deal with a lost or confused elderly individual wandering from home. A survey of police in Arkansas indicated that at least 25% of all missing adult reports entered into the FBI's National Criminal Information Center (NCIC) were for confused elderly individuals.

Wandering and becoming lost is the most life-threatening behavior associated with Alzheimer's disease. As many as 70% of people with Alzheimer's will wander and become lost sometime during the course of their disease. Wandering has been listed as a major cause of elderly hospital admission and death. It has been described by caregivers as the least manageable aspect they face, and it is noted as a primary factor leading to placement into long-term care.

Fortunately, fatalities from wandering are rare. Of about 125,000 Alzheimer's-related wandering cases that police departments handle each year, only 1% result in death. The secret to a happy ending is speed. About 40% of people with Alzheimer's who are lost more than 24

Editor's Note: America's booming elderly population poses special challenges for the law enforcement community, which is being trained to cope with everything from wandering Alzheimer's patients to elder abuse and mail fraud. "Law Enforcement's Newest Beat—Our Elderly" is an exclusive series that examines this very different policing approach. This first installment probes the unique 21st Century policing tactics required to deal with Alzheimer's victims.

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Caregiver's Home Companion is produced by caregivers and professional healthcare workers. While this publication is not intended as a substitute for professionally administered medical advice, the practical suggestions, advice and tips made in this newsletter have been tested or reviewed by an individual or organization involved in caring for elderly other loved ones. Caregiver's Home Companion also strives to obtain the input of educators and researchers in all branches of medical and scientific research. We welcome your comments and suggestions at [editor@caregivershome.com](mailto:editor@caregivershome.com).

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### Law Enforcement, *continued from page 1*

hours will be found dead, often from cold, dehydration, or exhaustion.

During the winter months, hypothermia becomes a very real concern for the lost individual. Police say they frequently find confused elders wandering dressed only in thin clothing and slippers, thus further exposing them to harsh weather conditions. Because Alzheimer's patients may not be able to realize whether they are properly dressed or how to find appropriate shelter, it is critical that they be found early.

Other difficulties surrounding locating Alzheimer's patients arise because they may be irrational, they may not respond to directions or their name, they may refuse help, or they may hide. They are also capable of making poor decisions, like walking into a pond or into thick brush. The irony is that most wanderers don't get much farther than a mile, but they can be challenging to find.

In order to better protect the elderly, police have turned to new strategies. Before the mid-1990s, most police officers were not taught about Alzheimer's. Then local Alzheimer's Association chapters began giving police departments limited training. Today, police departments build an officer's Alzheimer's expertise in several ways. In many departments, police recruits are offered seminars on finding and interacting with Alzheimer's patients, and Alzheimer's training is part of a continuing education program. The Alzheimer's Association has helped many states create a training program that is used in police academies and in continuing education.

Many police departments are trained and tapped into the Safe Return program. Federally funded but administered by the Alzheimer's Association, this program is a 24-hour database registry designed to safely locate lost Alzheimer's patients. Police, people with Alzheimer's or related disorders, families, and caregivers can access this program. Stories abound on how the program has ensured the safe return of many wandering souls found in places as varied as the mall or public transportation stations.

Some of the strategies police officers now use to locate lost Alzheimer's elders include immediate response, issuing a description on the NCIC network, issuing a radio or Teletype report to neighboring police departments, calling the Safe Return program, dog searches, neighborhood

grid searches, checking to see if subjects have visited an old workplace or old friend's homes triggered by long-term memory, displaying photos on TV news, rechecking the area where the person was last seen, communicating with officers on the next shift, and considering life-threatening health problems and the weather.

When wanderers are located, police officers are trained to be patient, speak in short sentences, approach from the front, make eye contact, keep instructions simple and positive, move the person to a quiet area, look for identification, become aware of potential dehydration and hypothermia, look for serious medical problems and necessary medications, avoid assuming the subject is intoxicated, avoid restraints, and understand typical emotional responses like difficulty communicating, sobbing, pacing, or trying to flee.

Once the person is identified, the police officer is taught to return them to their caregiver if they do not need medical attention and counsel the caregiver that wandering is a life-threatening behavior.

Police officers on the beat report that they see much improvement in the way they understand and respond to Alzheimer's cases. With Alzheimer's disease becoming a thread woven into American society, victims of the mind-robbing disease will need as much protection as they can possibly get. ■

## SAFE RETURN A Call or Click Away

Alzheimer's Association Safe Return is a nationwide identification, support and enrollment program that helps when a person with Alzheimer's or a related dementia wanders and becomes lost.

With round the clock assistance, if an enrollee is missing one call activates a community support network. With a \$40 enrollment in Alzheimer's Association Safe Return, enrollees receive an engraved identification bracelet or necklace, iron-on clothing labels, caregiver checklist, key chain, lapel pin, refrigerator magnet, stickers, and wallet cards.

For more information, contact the Alzheimer's Association National Office, 225 N. Michigan Ave., 17th Floor, Chicago, IL 60601, call the program's 24/7 Nationwide Contact Center at **(800) 272-3900**, or visit their website at: [www.alz.org/Services/SafeReturn.asp#more](http://www.alz.org/Services/SafeReturn.asp#more).



## Caregiver Peace of Mind

# How Personal Emergency Response Systems Can Protect Loved Ones

By Paula S. McCarron

**D**oes your aging or frail loved one live alone or spend long periods of time alone? If so, you are likely are nagged by these questions: What if my loved one needs help and can't get to the phone? And how would I know?

Veryl Ann Grace of Keaau, Hawaii, says she had those same concerns about her Aunt Louisa who lived alone at age 84. Though mentally sharp, Grace's aunt had multiple health problems and some difficulty walking.

Grace's fears turned into reality one Saturday afternoon. Running late for a scheduled visit, Grace phoned her aunt to let her know she would be late. Her aunt didn't answer the phone but as Grace says, "That was not totally unusual. If she was sleeping on her good ear or had the television turned up, she often didn't hear the phone."

She arrived to find her aunt's front

door open but the screen door latched. Seeing her aunt seated in a favorite chair, she called out. "My aunt answered me but her speech was not clear, I called again and then ripped the screen to get in. As soon as I saw her, I knew that she had had a stroke. I called 911. She was rushed to the hospital. She'd had a massive stroke and within three weeks she was dead."

What might have helped in this situation was a personal emergency response system—or PERS. Once marketed primarily to the frail elderly, personal emergency response systems allow an individual to call for help without having to dial a phone. These devices are increasingly popular with adults of all ages who have medical concerns, spend time alone, or simply want to ensure access to help in the event of an emergency on a 24-hour, 7-day a week basis.

How do these systems work? A small radio transmitter is placed inside a pen-

dant or bracelet that the individual wears at all times. When help is needed, the individual presses the "help" button located on the pendant or bracelet. A radio signal is sent to a console that has been connected to the home phone. The console then automatically dials one or more pre-selected phone numbers. Most often, the call goes first to a response center operated either by a PERS manufacturer or to a local provider of PERS services such as a hospital, healthcare or home care agency.

In most situations, the staff at the response center will then attempt to reach the individual to learn if an emergency exists. Depending on the situation, a family member, friend or neighbor may be contacted to make a "safety check" or lend assistance. If needed, the response center staff place calls to local emergency responders such as paramedics or police, as appropriate.

In addition to providing the ability to make a call for help during an emergency, some PERS offer features such as medication reminders, smoke detection, two-way voice communication, and intruder detection. Some are mobile systems supported by nationwide networks. Others detect inactivity or a fall.

"Fall detection units are very, very new. We've had them on the market for ▶

## Some Questions to Ask Before Acquiring a PERS

1. What costs, if any, are incurred due to services, repairs or warranties?
2. What is the range of the system? Test out the system to be certain calls can be placed from all areas of the home.
3. Is there 24/7 coverage by the call center?
4. What training do call center staff have?
5. How long has this company been in business?
6. What fees or costs will be assessed if I choose to discontinue this service?



PERS, continued from page 3

about a year," says Robin Snowden, chief operating officer of New England Emergency Response Systems. The technology of these systems is sensitive to the degree of impact, acceleration, and horizontal and vertical angles. Snowden says these systems can be of great value for people who are diabetic, epileptic or have dementia and may not be able to press the "help" call button.

Snowden says that in addition to the value of emergency response, PERS can offer individualized attention and care. "We have a customized database with detailed information on each of our clients. We track medical information, a listing of medications, and allergies. We even make notes like 'Don't let the cat escape out the door.'"

PERS vary greatly not only in features but also in price. PERS can be leased, purchased or rented. Installation may or may not involve additional fees. They are not covered under Medicare and only rarely covered by private insurance. In some states, Medicaid may provide coverage. On average, the monthly leasing fee runs between \$20 and \$40.

Many local chapters of the American Red Cross now provide personal emergency response systems as part of their mission to assist individuals in emergency preparedness.

Karen Tantama, preparedness product manager at the American Red Cross national headquarters, says, "Consumers should ask lots of questions before making a decision. Find out if there are charges for service calls. Ask what other services are included such as caregiver education. Find out who is going to answer that call when your loved one needs help."

Veryl Ann Grace learned the hard way that it's critically important to be prepared for an emergency. As she says, "I never voiced my fears or nagged. (It was) a mistake on my part. While I don't know if my aunt would have lived had help arrived, I do know she would have been helped to be comfortable much sooner." ■

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## Caregiver Grief

# Understanding the Myriad of Emotions Triggered by End-of-Life Decisions

By **Kenneth J. Doka**

**T**he wrenching and fateful decisions made at the end of a loved one's life can both facilitate and complicate grief for caregivers—sometimes simultaneously.

For example, in sudden death, which often results from accident, suicide or homicide, each cause of death creates unique issues for bereavement, but all share complicating factors, such as a sense that the death may have been preventable. These same factors also can complicate a sudden death from natural causes such as a heart attack, aneurysm or stroke.

In turn, ethical decisions, such as when to terminate treatment or stop heroic medical measures, are consequently often made while the caregiver is both in shock and grief, coming with little warning or time for thought.

A prolonged illness spawns other complicating factors. Family caregivers may be highly stressed as they cope with the incessant physical, financial, social and psychological demands of a loved one's life-threatening illness. It also can be difficult to witness the slow deterioration and pain expressed by the dying family member. With so much time passing, prolonged illness may generate considerable ambivalence as family members simultaneously wish for death and an end of the person's (and family's) suffering while concurrently wishing that the person would remain alive.

Caregiver ambivalence may also develop as the loved one's physical appearance deteriorates to such an extent that family members are repulsed even as they seek to care and to comfort.

What this all leads to is this: End-of-life dilemmas themselves can reflect and



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## The best end-of-life decisions are made in a reflective process where the individual has time to consult with medical personnel as well as other family members.

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even generate considerable ambivalence. The individual or family making the decision can be torn between a desire to end suffering and a continued quest to retain hope even in the midst of impending death. They may experience conflict between following their own beliefs and choices while honoring the expressed wishes or beliefs of the deceased.

Normally, one person within the family system may hold the health proxy. Such a proxy in the United States authorizes a given person to make medical decisions for an individual incapable of making such decisions. Families may differ in their abilities to communicate with one another and in their opinions about what should be done. Thus, end-of-life decisions can create family conflicts or revive family disputes.

The manner of death, too, may complicate subsequent grief. Even the decision to terminate life support may not ensure an easy death. Family members may even interpret or misinterpret the final actions of the dying person as evidence of pain.

There's no escaping this dilemma — even decisions to continue treatment may generate issues. Families may feel, in retrospect, that they have let a loved one needlessly suffer. They may sense the active disapproval and even isolation of medical personnel because of their decision (yes, this does happen). In other cases, the pain and suffering experienced by the dying individual may create a situation where family decision-makers wish they took a more proactive role to end suffering.

End-of-life decisions may not only compound bereavement. In some cases, active decision-making at the end of life can be a facilitating factor, easing the

strains of grief. Individual end-of-life decisions can provide a sense of control — allowing a semblance of control at an otherwise uncontrollable time.

Moreover, these decisions may be the end result of a process that is therapeutic. The best end-of-life decisions are made in a reflective process where the individual has time to consult with medical personnel as well as other family members. The process can do much to ease subsequent grief. It can allow a process of consensus building that can generate support and ease isolation at a very difficult moment. It can offer additional information and discussion that acknowledges the inevitability of death and the futility of further medical interventions. It also can assist survivors in accepting the reality of death.

The decision-making process can provide opportunity to confront painful emotions and finish unfinished business. In some cases, this reflective process provokes strong spiritual reflection as one assesses not only how one's philosophy or theology address the ethical issues involved but also how one's spirituality more directly speaks to the very loss. An individual may define the decision-making process as one that enabled a loved one to die a good death, perhaps by easing pain or fulfilling that person's wishes.

The grief of family members flows when family members are encouraged to have a deliberative and inclusive process. Decisions to terminate treatment arouse strong feelings of ambivalence. Individuals report that they rely on family and friends to help make their end-of-life decisions. Such consulting is critical as it also develops a greater level of consensus and subsequent support. However, such a process does take time. And this time allows the family an opportunity to

weave their decisions into a consistent narrative of the patient's illness and death, in other words they come to terms with the end.

This process cannot be rushed. For families engaged in the process, it is critical that physicians and others do not attempt to apply pressure to quicken that process.

Moreover, the process may not end and with the loved one's death. After the death, patients may need to review the decisions they made in the course of the illness. Physicians need to understand this as a critical aspect of care and one that is both necessary and facilitative of the grieving process.

Ethical decisions never arise in a vacuum. Culture, technology, social and individual values, spiritual and religious tradition, and legal struggles are among the many factors that frame ethics. Ethical decisions do not proceed in a vacuum either. Decisions that have been made may continue to be reconsidered and reviewed long after the choice and their loved one has died. ■

### COMING UP IN FEBRUARY

- Elderly driving safety, elder abuse, mail fraud and victimization are all challenges for law enforcement today—and examined in Part 2 of our exclusive series *Law Enforcement's Newest Beat—Our Elderly*.
- What are reverse mortgages, and when are they the right answer for my elderly ones?
- Keeping love alive in a most stressful situation, 24/7 spousal caregiving.
- Six strategies for successful long-distance caregiving.

## Tricks of the Trade

# Keeping Caregiver Stress at Bay

By Jacqueline Marcell

**C**aring for a chronically ill loved one can be one of life's greatest challenges. Caregivers often feel guilty and frustrated for not accomplishing all the tasks they once did. And even though they do so much every day, they often feel that they are not doing enough, or that what they are doing could be done better.

In addition, fond memories of past times, when a loved one was still healthy, can cause a cascade of caregiver feelings of loss and sadness, creating a downward spiral that can be difficult to recover from.

More than 50 million people, one in every five Americans, help elderly loved ones who can no longer help themselves. But when caring for another, a caregiver often neglects their own well-being, oftentimes not even seeing them self as a caregiver, but simply as someone doing what any loving family member would do. "I'm just taking care of my mom" is a common refrain.

I have lived through this heartache, caring for my elderly parents for several years, both with numerous health problems and the beginning of dementia, namely Alzheimer's disease. How I wish I'd known sooner how to cope with the overwhelming stress, tears and sorrow. But, hopefully, these lessons can help you:

### Nurture Yourself

You can't be an effective caregiver if you are so stressed that you get sick too. As hard as it is to find the time and motivation, realize that it's imperative that you take good care for yourself.

- **Eat healthy:** set limits on high fat and processed foods, caffeine and sugar-laden treats that can increase fatigue.

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*Jacqueline Marcell is an author, publisher, radio host, national speaker, and advocate for eldercare awareness and reform. Her writing includes Elder Rage, or Take My Father... Please! How to Survive Caring For Aging Parents. For more information, see [www.ElderRage.com](http://www.ElderRage.com).*

- **Exercise often:** take a walk, stretch, lift weights, do isometrics.
- **Get proper sleep:** take naps when necessary.
- **Meditate:** practice deep breathing and visualization.
- **Attend a support group regularly:** solutions will present themselves.
- **Get respite care for your loved one:** the break will help you.
- **Do things you enjoy:** read, music, hobbies, crafts, movies, etc.
- **Use a hand sanitizer:** viral and bacterial infections can be reduced.
- **Treat depression:** if chronically depressed, find a therapist, and ask your doctor to consider prescribing an anti-depressant.
- **Get yearly physicals and all appropriate tests:** mammogram, prostate, colonoscopy, etc.

### Organize

Pace yourself, being careful not to take on more than you can manage. Make lists of things that must be done, and secondary lists of things you would like to accomplish if possible. Be sure to set strict limits with yourself and others of what you can and what you cannot do.

### Ask For Help

Don't wait for friends and family to ask what kind of help you need. Instead, make a list of chores and ask everyone to pick the tasks they feel comfortable with. In addition to the long list of caregiving chores, add: cleaning the house/garage/pantry, taking the car in for service/tire rotation, gardening, shopping, cooking meals ahead for the freezer, etc.

### Accept Invitations

Even if you don't feel like going out at the moment, having activities to look forward to will help you feel less isolated and deprived of a normal life. If your loved one can't attend with you, arrange for their care with family, friends, or through a caregiving agency. Be aware that having



fun, laughing, and focusing on subjects other than caregiving and ill health, will help to keep you in emotional balance.

### Use Adult Day Care

Consider enrolling your loved one in adult day care, which is often the very best thing for them, as well as for you. They are kept busy with activities they enjoy, and you get a break for several hours a day, which will help recharge your batteries.

### Reach Out For Help

Many resources are available to help caregivers. Consider hiring a geriatric care manager, who can personally guide you through the complicated maze of eldercare. Also, faith-based organizations often offer support to family caregivers.

As former First Lady Rosalynn Carter says, "There are only four kinds of people in the world: Those who have been caregivers; those who currently are caregivers; those who will be caregivers; and those who will need caregivers." Realize that what you are doing is very challenging, though not unique, and that there is help available. And remember, someday, someone may be caring for you, so be sure to plan for good Karma! ■

## HANDY NUMBERS

Area Agency on Aging or Department of Aging,  
Family Caregiver Support Program: (800) 422-3263

Meals on Wheels: (703) 548-5558

Eldercare Locator: (800) 677-1116

Alzheimer's Association: (800) 272-3900

National Family Caregivers Association:  
(800) 896-3650

National Adult Day Services Association:  
(212) 494-0755

Rosalynn Carter Institute for Caregiving:  
(229) 928-1234



Never Too Late to Learn

# Caregiver Training Programs Are a Valuable Resource

By Ursula Furi-Perry

Caring for a loved one can be a complex and difficult job, and the complexity only intensifies when caregivers aren't certain that they're "doing the job right." Even seemingly simple tasks, like turning a loved one over in bed, can become daunting when a caregiver is unsure how to do them.

Caregiver training programs can help take the guess-work out of caring for a loved one. "These training programs may help prevent small problems from becoming larger," says Jeanne Erdtmann, registered nurse and preparedness expert for the American Red Cross. "They may also empower caregivers and protect them (by letting them know) they're taking the right course of action when caring for a loved one."

Caregiver training classes cover a vast number of topics. "Our classes cover basic care procedures and safety issues," says Gaea Yudron, spokeswoman for Healing Arts Communications, which distributes a national caregiver training program to agencies on aging, state health departments, and many other organizations.

"(Caregivers can learn) ways of completing tasks which don't have to take place in a routine setting, like bathing or shaving, for example," says Cathy Klintworth, RN, BSN, quality assurance supervisor for the Area Agency on Aging. "Caregivers need to know different alternatives (when meeting their loved one's needs)."

In addition to task-based, physical benefits, caregivers may learn a lot about coping with caregiving on an emotional and mental level. "We also give caregivers techniques for positive communication in specialized situations, like Alzheimer's and dementia," Yudron says. "Those techniques help caregivers to look at the issues from the loved one's standpoint and put themselves (in the loved one's shoes)."

Home safety is another area emphasized by the programs. "It's important to receive training on setting up and practicing emergency plans, preventing falls, and even handling special equipment like nebulizers or oxygen tanks," Klintworth believes.

The Red Cross follows a modular method in its caregiver training program, so that the program is convenient and flexible for busy caretakers. "Each subject is about an hour long," says Erdtmann, and topics include home safety, nutrition, general caregiving skills, assisting with personal care, legal and financial issues, and even caring for the caregiver. "We understand that caregivers don't have a lot of time, and perhaps their biggest struggle is fitting the classes into their schedules. That's why we wanted to offer hour-long, modular classes, so that caregivers could choose their subject areas of interest."

For caregivers who can't spare even an hour outside the house, many agencies offer in-home training sessions. "One-on-one, in-home training will address each individual's unique needs and gear the training for the caregiver's own situation," says Klintworth. "We also offer adult day-care alternatives or in-home respite care during training sessions." Naturally, these alternatives will help the caregiver focus on training and take his or her worries off the loved one, if only temporarily.

In addition to private classes, valuable videos, books, and manuals are available for caregivers. Healing Arts sells a series of *Quick Tips for Caregivers* books and workbooks and also distributes videos to libraries and county health departments so caregivers can borrow them as needed. The Red Cross also sells home reference kits through its website, with videos and DVD's that provide caregivers another avenue for getting information.

Those who can, however, should consider a class setting for their training. "In

class, caregivers may meet others who are going through a similar situation," Yudron explains. "It's important for caregivers to reach out and connect with others while learning skills that will make their jobs easier." In addition to offering a great place for support, training courses can be a springboard for further information and help. "The courses can help caregivers identify valuable resources," Erdtmann says.

And where can a caregiver find training programs in his or her area? "Start with your local Area Agency on Aging, or call a national or local caregivers' support program," Yudron recommends. Other good places to begin include county and city health departments, public libraries, trusted hospitals, noted caregiver organizations, and the loved one's physician.

Ideally, caregivers will take preparedness classes before beginning the caretaking process. "This will build confidence that the caregiver can help when a tough situation arises," Erdtmann says. But it's never too late to enroll: continuing education can keep caregivers on their toes about new methods of coping with their tough tasks. In fact, if you're thinking about hiring someone to help with caregiving responsibilities—or even recruiting family and friends to do the same—consider enrolling them in a training program as well.

"It's important to have professional input in the caregiving process," says Klintworth. "Training can eliminate a lot of fears. In fact, many individuals may push for nursing home placement because they are afraid of what they'll be expected to do." To help face those fears, learn innovative methods of caring for your loved one, and interact with professionals and other family caretakers, consider going through caregiver training—the programs will be well worth your time.

*Ursula Furi-Perry is a freelance writer based in Woburn, Massachusetts. She can be reached at perry11@rcn.com.*



# A PORTRAIT OF OLDER AMERICA'S HEALTH, BY THE NUMBERS



Caregivers most often draw a picture of older Americans through their eyes and experience caring for their own elderly loved ones. But how does that view stack up against the government's research picture of this fast-growing population segment?

The recently-released government study *Older Americans 2004: Key Indicators of Well-Being* concludes that the 12% of our population over age 65 is generally healthier, wealthier, and better educated than previous generations, but these gains have not been equal. Here are highlights of their health research:

- Americans are living longer than ever before. Life expectancy at age 65 increased to more than 19 years for women and about 16 years for men, and at age 85 it was 7 years for women and 6 years for men.
- The age-adjusted proportion of older Americans with a chronic disability declined from about 25% in 1984 to 20% in 1999 (most recent data). The disabled declined from 19% to 15% for men 65 and over and from 28% to 23% for women 65 and over.
- In 2002, nearly half of all older men and nearly a third of older

- women reported trouble hearing without a hearing aid. Vision problems, even with glasses or contact lenses, affected 18% of the older population, specifically 16% of men and 19% of women.
  - There's a dramatic increase in elderly obesity. In 1999–2002, 69% of our elderly were overweight or obese. Between 1976–1980 and 1999–2002, people 65–74 who were overweight or obese rose from 57% to 73%; those who were obese doubled from 18% to 36%.
  - Older men who currently smoke dropped from 29% in 1965 to 10% in 2002. In turn, women smokers declined only slightly from 10% to 9% in 2002.
  - Medicare pays for just over half (54%) of the overall healthcare costs of its enrollees. This population pays 21% of their healthcare costs out-of-pocket. Medicaid covers 10%, and other payers, primarily private insurers, cover 15% more.
  - Average prescription drug costs for older Americans increased rapidly throughout the 1990s, especially after 1997. Average costs per non-institutionalized Medicare enrollee were \$1,340 in 2000. Their average number of filled prescriptions rose substantially over time, averaging 18 filled prescriptions in 1992 and 30 filled in 2000.
- The complete report is available from the National Center for Health Statistics by calling toll free 866-441-NCHS (6247) or by sending an e-mail to [nchsquery@cdc.gov](mailto:nchsquery@cdc.gov). ■

## Give the Lasting Gift of Care

how you care to those around you who can benefit from the same information, tips, advice and how-to features you receive every month in *Caregiver's Home Companion*.

Give a gift subscription to the newsletter so the help and benefit you receive can be shared by others you care about.

Give the gift of help—a gift subscription to a family member, friend or co-worker.

Or donate an anonymous gift subscription which we will use to benefit an individual in need of the knowledge and support *Caregiver's Home Companion* provides, but may not be able to afford the few extra dollars to subscribe. We will see that your gift is properly assigned to a needy caregiver.\*

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Call NOW toll free at (877) 259-1977, or fill out the simple gift subscription form online at <https://www.caregivershome.com/subscriptions/giftsubscriptions.cfm>.

\* Note: anonymous subscription donations may only be submitted by using our toll free phone line.



**Caregiver's HOME COMPANION**  
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**Alcohol and the Elderly: An All-too-Common Bond with Serious Consequences**  
 By Paula McGee

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**Alcohol and the Elderly: An All-too-Common Bond with Serious Consequences**

Alcohol consumption is a common part of life for many people, but for older Americans, it can be a double-edged sword. While moderate drinking can be beneficial, excessive alcohol use can lead to serious health problems, including liver disease, heart disease, and high blood pressure. For older adults, the effects of alcohol can be even more pronounced due to changes in metabolism and the potential for drug interactions.

Research shows that older adults who drink alcohol are more likely to have chronic health conditions and are at a higher risk of falls and injuries. Additionally, alcohol use can exacerbate cognitive decline and increase the risk of dementia. It is important for caregivers to be aware of their loved ones' alcohol consumption and to encourage moderation or abstinence if necessary.

For more information on alcohol and the elderly, visit our website at [www.caregivershome.com](http://www.caregivershome.com).

**Cruciality to Help eging Stress**

Stress is a natural part of life, but for caregivers, it can be overwhelming. The constant demands of caring for an elderly loved one can lead to physical and emotional exhaustion. It is essential for caregivers to take time for themselves and to seek support when needed.

One effective way to manage stress is through relaxation techniques, such as deep breathing, meditation, and yoga. These practices can help reduce tension and promote a sense of calm. Additionally, joining a caregiver support group can provide a valuable outlet for sharing experiences and receiving encouragement from others who understand the challenges of caregiving.

Remember, you cannot care for others if you are not taking care of yourself. Prioritize your own well-being and reach out for help when you need it.

**RESOURCES**

For more information on alcohol and the elderly, visit our website at [www.caregivershome.com](http://www.caregivershome.com). You can also contact our toll-free helpline at (877) 259-1977.

Additional resources include:

- **National Institute on Alcohol Abuse and Alcoholism (NIAAA)**: [www.niaaa.nih.gov](http://www.niaaa.nih.gov)
- **Alcoholism Treatment Centers**: [www.alcoholism-treatment.com](http://www.alcoholism-treatment.com)
- **Alcoholics Anonymous (AA)**: [www.aa.org](http://www.aa.org)