Best Practices Around Older Adults and Alcohol

A Background Document prepared for
Seeking Solutions:
Canadian Community Action For Seniors and Alcohol Abuse

February 2nd and 3rd, 2001, Ottawa

Best Practices Around Older Adults and Alcohol

Prepared by Charmaine Spencer, Gerontology Research Centre, Simon Fraser University, (email : cspencer@shaw.ca), with special thanks to the ideas contributed by Margaret Flower (OPUS-55), Rheena Diabo (Kahnawake Shakotiia'takehnhas Community Services), and Jennifer Barr (CAMH, Peterborough).

This is document is prepared for the national project: Seeking Solutions: Canadian Community Action on Seniors and Alcohol Issues, an initiative funded through Health Canada, National Population Health Project. Our many thanks to Health Canada for making this possible.

Table of Contents

1. Introduction

The demographics of Canadian society are changing rapidly. Today, there is a significantly larger percentage of people entering into their 60s and 70s, and living into their 80s, 90s and beyond. In 1998, there were an estimated 3.7 million Canadians aged 65 and over, up almost 60% from 2.4 million in 1981. In fact, the senior population has grown more than twice as fast as the overall population since the early 1980s.

With these changes, there has been a growing awareness of the importance of older adults' needs in many sectors, but not all. Some social and health problems experienced by older adults, such as alcohol misuse and abuse, can easily be set aside and go unaddressed in many communities. This can happen for many reasons, including resources that are already stretched thin and the perception that "it's too late in the game"

A. The Purpose of this Background Document

This paper has been prepared for a national meeting in Ottawa, Ontario being held February 2nd and 3rd, 2001 on Seniors and Alcohol Issues. The meeting is part of a larger three year national project called *Seeking Solutions: Canadian Community Action for Seniors and Alcohol Abuse*, funded by the National Population Health Fund.

The purpose of the paper and the meeting is not so much to say, "These are the best practices", but to "provide food for thought". With it we would like to

1. Encourage people to think "What do we mean by the term 'best practices' in the context of older adults and alcohol?"
2. Identify some preliminary approaches that people are finding are effective when working with older adults as clients, when working with older adults generally, or with working with others in their community;
3. Raise questions on where are the current gaps in knowledge and approaches;
4. Help people think about what could be guiding principles in this area;
5. Give a context for evaluating something as best practice as it relates to alcohol issues affecting older adults;
6. Aid people's understanding of why best practices are so important.

The paper is divided into four main areas, focusing on considering best practices and effective approaches in

1. providing information and education;
2. treatment;
3. community development; and
4. policy and research.

B. What Do We Mean by "Best Practices"

In this document, we are using the term "best practices" broadly. Generally, the term will refer to approaches which are shown ("proven") to be effective for a group of people. A best practice can be identified through people's experience (clinical or otherwise) or through literature reviews of studies.

At present, there is only a small body of Canadian literature on older adults and alcohol as an issue, let alone on identifying and comparing approaches being taken to determine the best ways to reach, support and assist older adults who are experiencing alcohol problems.[1] In using a broad approach to best practices, we recognize that this is different than the way the term "best practices" may be used in the scientific or medical literature.

We ask people to keep in mind several things as they consider best practices in their area or their community:

- what works in the individual case may not be what works for many older adults (or vice versa);
- what works for many communities may not work for a specific one, and very importantly;
- what a community, an individual or agency has been doing for a long time is not necessarily a best practice.

To some extent, some best practices are created when people identify the things learned along the way that do not work for older adults. Best practices evolve over time.

Reference to "best practices" does not mean to imply that previous practices were "bad". In most cases, best practices reflect that we have learned more about the nature of alcohol problems among older adults

to a certain point. Knowledge can change over time as people develop a better understanding of the older person's needs and existing barriers to having those needs met.

C. Why Best Practices?

It sounds almost foolish, but why would anyone want to use anything other than the best known practices possible? Many times, we respond the way we were originally taught or told, even though subsequent experience may lead us to question those practices.

Best practices should have the effect of helping to better meet the needs of the group being assisted. When dealing with alcohol issues, the goal is to improve older adults' understanding of alcohol issues, as well as improve their access to treatment and the kind of assistance that they receive. This is an important aspect of respecting the person, as well as fair and equitable treatment.

There are also many benefits to a program or agency using best practices. These include

- better outcomes for older clients and more satisfaction with the process and the outcomes,
- more referrals, and
- more confident and less stressed practitioners.

Staff may have a better sense of work satisfaction when the goals of best practice are demonstrated by all the staff and are modelled by management.

D. Some Guiding Principles

There are certain values are fundamental to developing community programming for older adults, whether that is for alcohol issues, or any other need. These are that older adults need to be treated with dignity, purpose, self-esteem, respect, fairness, equity and compassion. [2] Multi-faceted approaches are needed to deal sensitively and appropriately with the diverse needs of different older adults. Programs and services directed to older adults will need to recognize and value older adults' differing needs, as well as recognize ways that older adults can contribute to the development and enhancement of programs.[3]

2. Background Information

A. Alcohol Consumption Among Older Adults

Alcohol is the most common drug used by older adults. [4] According to 1998 data, 54% of Canadian women and 67% men aged 65 over consumed alcohol. This is a slight change from 1995 and 1996 figures (53 - 58% for women and 71-73% for men aged 65 and over). [5] Alcohol consumption, on average, tends to decline among older adults, but older adults who do drink are also twice as likely as younger adults to consume four drinks or more a week.[6]

	1998-1999				
	Type of drinker				
	Population estimate	**Regular**	**Occasional**	**Non-drinker now**	**Abstainer**
	thousands	%			
55-64	**2,678**	**55**	**19**	**17**	**8**
Male	1,342	66	14	15	5
Female	1,336	44	25	20	11
65-74	**1,993**	**44**	**23**	**21**	**12**
Male	901	53	19	22	6
Female	1,092	36	26	20	18
75+	**1,471**	**30**	**21**	**29**	**20**
Male	601	42	19	27	11
Female	870	22	23	30	--

Source: Statistics Canada.

B. Alcohol Misuse and Abuse Among Older Adults

For most older adults, alcohol consumption is not a problem in their lives. However, approximately 6-10% of older adults who drink experience alcohol problems at some point in their later years. That represents an estimated 138,000-220,000 older adults across Canada.[7]

Some populations of older adults are at much higher risk of having an alcohol problem develop. Between 18% and 55% of older adults admitted to hospital; living in Veterans housing; or living in care facilities (nursing

homes etc.) use or have used alcohol to an extent that it has negatively affected their health, independence and their quality of life. [8]

Some older adults' alcohol consumption does not change much over the years. However, physiological changes associated with aging (less body water, the slower speed at which the kidneys and liver in the older body break down the alcohol in the body etc.) can accentuate the effect of the alcohol for an older adult, creating more harm with less drug.

C. Types of Alcohol Abuse

Alcohol problems among older adults are frequently divided into two loosely defined categories: late and early onset. **Early onset** typically refers to when the person has been a heavy drinker throughout their life, and **late onset** refers to where the level of alcohol consumption becomes problematic later in the person's life (post-retirement, after loss of spouse, in responses to changes in health and independence). Some people add a third category – **crisis onse**t. This is where a person may have long periods of sobriety (months or years) or problem free drinking, but restarts or heavily increases drinking in response to major changes or problems occurring in his or her life.

There is no "typical" older person with an alcohol problem. The level of alcohol consumption among older adults, in general, tends to be higher among older adults who have low income and (at the other end of the economic spectrum) among those older adults who have relatively high income.

The older adult developing an alcohol problem can easily be

- a 83 year old grandmother of six
- a 66 year old retired government employee who worked in a managerial capacity
- a WWII veteran
- a homeless man of 55
- the 73 year old woman volunteering at a senior's center

or almost any other person who is part of the wide range of older adults in Canadian society. Alcohol problems among older adults are not limited to any gender, any race or ethic group, people of any particular income level. They can be adults who are relatively healthy, in reasonable health "for their age", or who are very disabled.

D. The Effects of Alcohol Misuse or Abuse

Consuming alcohol at unsafe levels adversely affects older adults' health in many ways. Perhaps most importantly, from the individual's perspective, it threatens their ability to live independently. It can also increase an older adult's risk of falls, compromise the person's mobility, and decrease the person's cognitive ability.[9] Alcohol problems among older adults are frequently tied to social isolation. Alcohol problems among older adults can also affect the person's family. In other cases, people are responding to an older adult's alcohol problem because it is having a negative effect on their service delivery.

E. Alcohol – Medication Interactions

The majority of older adults (84%) take some form of prescription or over-the-counter medication.[10] Almost two thirds of people aged 85 and over are more likely to take more than one medication, compared to 52% of those aged 65-74. The most common medications being taken by older adults are:

- pain relievers (62%)
- medication for blood pressure (33%),
- other types of heart medication (19%),
- stomach remedies (11%),
- diuretics or water pills (11%), and
- cough or cold medication (10%).

There are over 150 medications commonly prescribed for older adults that adversely interact with alcohol.[11]Alcohol can interact with medications used in treating various diseases either by exaggerating or blocking the effect of the drug.

F. Alcohol and Chronic Diseases/Problems

Excessive alcohol consumption is associated with a variety of medical and social problems. Here are some of the medical conditions caused by or worsened by alcohol consumption:

- *Hypertension/heart disease* - Alcohol can contribute to the onset and worsening of high blood pressure (hypertension) by increasing the pressure in the blood vessels. A person's blood pressure rises when they consume three or more drinks.

- *Diabetes* - Alcohol makes diabetes difficult to control and can elevate a person's blood glucose levels. Alcohol can contribute to other complications of diabetes. These include problems with vision (glaucoma) and diseases of the nervous system which results primarily in loss of feeling in the person's legs and feet.

- *Peptic ulcers/esophogeal reflux* - Alcohol frequently irritates the digestive tract and damages the lining of the stomach. That can worsen conditions such as peptic ulcers.

- *Pulmonary disease/COPD (chronic obstructive pulmonary disease)*- People who use alcohol excessively are at greater risk for lung disease, lung infections, and lung damage. Many older adults who consume higher levels of alcohol are also heavy smokers.

- *Weight control* - Alcohol provides "empty calories"--that is, no nutritional value. Empty calories contribute to increased body weight which in turn can contribute to problems in managing both hypertension and diabetes.

G. Alcohol and Stigma

In Canada we seem to have a love – hate relationship with alcohol and more particularly with alcohol problems. Most people consider it acceptable to drink, but not to "be drunk". Or it is more acceptable for some people to drink to excess (men, younger people) than others (women, older people).

Our understanding of what an alcohol problem looks like and how best to respond are often shaped by what we read, and what we hear from others, including the media. We are also still struggling for a common

understanding about how, when and why alcohol becomes a problem in people's lives. Perhaps as a result, for many adults, and particularly older adults, having an alcohol problem means being stigmatized.

By the term "stigma" and "stigmatized", we mean where certain individuals and groups are unjustifiably treated as shameful, excluded and discriminated against. This can involve being

- blamed for the condition happening (as identified by the belief "you decided to drink... you are responsible for all the results...")
- socially isolated
- degraded and treated as less worthy than people who do not have an alcohol problem
- being denied access to services and programs that other older adults in the same circumstances ("but for the alcohol") would normally have access to.

Stigma shows up in the ways that people react when alcohol becomes a problem in an older adult's life. The reactions can range from confrontation ("how could you...?") to raised eyebrows to silence and indifference. Stigma also affects the ways that people experiencing an alcohol problem judge themselves.

The Canadian Mental Health Association and the Centre for Addiction and Mental Health ("CAM-H") have both recognized the significant ways that stigma affects our understanding of and response to conditions such as mental health or addictions. In their May, 2000 newsletter, CAM-H published "10 Ways to Fight Stigma."[12] Among other things, they stress the need to

- go beyond the stereotypes and labels;
- listen to people who have experienced the condition;
- talk openly about the condition, watch our language and avoid using terms and expressions in our practice that may perpetuate stigma;
- learn more about the condition (attitudes are often based on misinformation or out of date information); and
- demand changes at a policy and resource level around policies that perpetuate the stigma for that condition.

In the context of older adults who have alcohol problems, we need to be aware that the more alcohol problems among older adults remain hidden, the more people (the older adult, family, practitioners, community supports) will believe it is shameful and needs to be

concealed. It means that we need to avoid depersonalizing older people who have alcohol problems by referring to them generically as "the older alcoholic" or by referring to individuals as their disease: "an alcoholic". It also means carefully considering whether we should use terms like "alcoholic" at all in the first place, or whether we should be replacing them with more accurate terms such as "alcohol dependency".[13]

Some Points to Consider

- What messages are being presented in the popular media (e.g., in soap operas, news items about famous people) about what needs to happen if a person has an alcohol or other drug problem?
- What are some of the ways that older people who have alcohol problems become stigmatized?
- In what ways are we stigmatizing, patronizing or condescending to older people in our personal actions, our attitudes, or in the language we use within our different professions, in the information we provide, in the treatment approaches, in our policy development?
- What are some of the ways we can reduce these stigmas?

3. Best Practices in Public Education Information

It is generally recognized that there is a "continuum of risk" with regard to alcohol consumption. (Some people do not drink, some drink alcohol at low levels, some drink infrequently but when they do ("special occasions") they may put themselves and others at risk by driving drunk, some people drink at high levels on an ongoing basis or in short spurts ("binge drinking") to a degree that it can serious compromise their health.)

As a result of these different situations and realities, it is recognized that there is a need for "continuum of education" (different types of education needed for different people about different alcohol issues and situations).

Some Points to Consider

- What are the types of alcohol information currently being provided to older adults?

- What kinds of information do we currently have for that continuum of education as it relates to older adults?

Much of the information on alcohol use or abuse is currently provided to people in written forms (a brochure, a guide book, on the Internet). It is important to consider

- What messages are we currently providing?

- Is the message is getting to older adults, and if not?

- What are the barriers?

A. Education and Literacy

By the time people have reached their later years, they bring a lifetime of experience. However, older adults have, on average, less formal schooling compared to younger adults.[14] In fact, the majority of today's older adults, over six out of ten, never completed high school. Almost 4 out of 10 (37%) of people aged 65 and over have less than a Grade 9 education.[15]

Partly as a result of their lack of opportunity to receive much formal education, many older adults have difficulty reading written material. According to the 1994 International Adult Literacy Survey, over half (53%) of Canadian aged 65 and over can have difficulty perform simple reading tasks. This is an important consideration in terms of general education strategies around alcohol issues. Literacy is also an important issue for older adults in the area of alcohol treatment because so much of the work ("homework") in treatment for the general adult population is based on reading materials, and writing and reflecting on one's thoughts.

In addition, people with low literacy skills may not be able to understand the written information fully and apply it properly to their particular health situation.[16] This would seem to suggest that we need to always be thinking of alternatives ways to convey information about alcohol to older adults in public messages, prevention education, counselling and other areas of treatment.

The Division of Aging and Seniors stresses: "Communicators should never equate limited literacy with a limited capacity to understand."[17] Lack of education and lower literacy skills will affect the types of information best suited for older adults and the way the information needs to be delivered.[18] It may have other less obvious effects too, such as affecting people's overall confidence in themselves in a rapidly changing society.

B. Delivering the Message

The diversity of social circumstances among older adults also affects how to deliver information about alcohol issues to them. People's access to information about any health or social issue often depends on where they live, how they communicate, who they know and who they trust.

While there are new sources that many older adults are turning to (such as the Internet), the percentage of older adults with computers (particularly among those who are widowed, separated, divorced) is still much lower than the younger adult population. Those with access will tend to have higher incomes and higher education. At the same time, it may be that the people who older adults turn to for information (as opposed to older adults themselves) may be the people for whom the Internet could be a good information resource.

Delivering the message about alcohol as an issue affecting older adults has tended to be limited to narrow venues. Is it possible to broaden this

discussion and "normalize" alcohol discussions? For example, in what ways can local community resources (such as pharmacists and pharmacies, and other health service providers) be included effectively in older adult public education on alcohol issues (e.g. aiding the knowledge about alcohol and medication interactions, aiding the discussion of how alcohol use increase might increase during caregiving?)

Some Points to Consider

- How can communities provide information on alcohol issues to people, places and sources that older adults trust?
- Is it possible to broaden the message about the impact of alcohol into other contexts (such as fall prevention, diabetes clinics, cancer clinics, caregiver support groups etc.)?
- Who is guiding the message we are currently providing to older adults? Are there ways of involving older adults in that process and giving that message?

C. The Content of Messages

Another important consideration is "What type of messages need to be conveyed to older adults?" Is it that a beer, or a sherry, or a shot of rye are all alcohol and are equivalent? That many over the counter medications have alcohol hidden in them? Is it about understanding the potentially positive effects as well as the negative effects of alcohol consumption? Or other messages?

Some Points to Consider

One of the common messages in education materials is the need to reduce the adverse impact of negative health practices (such as drinking alcohol at unsafe levels). As part of that, low risk drinking guidelines have been developed. Low risk drinking guidelines typically given for adults are 14 drinks a week for men and nine drinks a week for women, with no more than two drinks on any given day. In light of the fact that as people age, their bodies metabolize alcohol differently and given the reality that the

majority of older adults are on one or more medications that can interact with alcohol, it would be helpful to consider:

- Are the current low risk guidelines being used in public education messages accurate vis à vis older adults?

- Is the information clear to older adults? Can they accurately determine what their risk is?

Other Points to Consider

Are some of the educational messages being given in alcohol prevention too simplistic and unrealistic? For example, a common message is "Some people drink when they are lonely, if you are feeling lonely, get out and socialize". It is also important to consider whether some messages being given about older adults and alcohol are ambiguous or clearly wrong?[19]

- What are ways that we can assure the educational messages are helpful and accurate?

4. Best Practices in Working with People Who are in Contact With Older Adults

Addiction counsellors who help older adults often find that they have more contact with (and sometimes more in common with) agencies and individuals who provide social and health services to older adults (nursing, home support, senior services) than they have to others in the addiction field.

That leads to several questions:

- What are the opportunities to communicate, inform and work with people who are already in close contact with older adults?

- What are ways of strengthening the ties of counsellors working with older adults with others working in addictions?

- What are effective ways of raising the awareness of aging issues generally in the addictions field?

Communication of addiction concepts and goals to others is critical in this area, and that creates challenges. Service providers and others may be unclear about what addictions programs do and may not be receiving information at a level that is clearly understandable to them. Part of this is because addictions treatment carries a whole vocabulary (jargon) as well as a variety of counselling approaches that may not be easily understood by others outside the field.

Yet it is more than just the concepts that cause difficulties. Some approaches, such as harm reduction, may feel "counter-intuitive" to some people. This may reflect the popular understanding of addictions as following a medical/ disease model.

What's in a Word?

The term "harm reduction" can actually mean different things to different people in addiction treatment. To some, it means only "we do not require the older adult to have abstinence as his or her initial goal".

For others, it means something much broader. It is referring to an approach where people work to support the person by addressing not only the alcohol problem (information and support) but by also helping the older adult with other areas that are causing him or her concern or are having an impact on the alcohol problem (in other words, helping to reduce those harms so that a person will be in a better position to make changes.)

5. Best Practices in Identification and Assessment

Alcohol problems among older people often go unrecognized for a long time. There are several reasons this is the case, including

- out of date information that does not reflect the diversity of alcohol problems,
- ageism,
- stereotypes about who may develop an alcohol problem and
- limitations to the existing assessment tools.

Most of the current tools including DSM IV-R; MAST (although there is a "geriatric" version); and the CAGE questionnaire, have been developed with a younger population and from criteria relevant to their lives. However, perhaps the greatest hurdle is not the lack of formal assessment tools standardized for older adults, but the lack of ease that people have about asking questions in this area.

Some Points to Consider

- What are the kinds of indicators commonly being cited in the aging, health and addictions literatures for an alcohol problem?

- To what extent do those "common indicators" accurately reflect what is known about alcohol problems for older adults?

A. Identification

In the United States, Treatment Improvement Protocol (TIPS) Series, No. 26 on *Substance Abuse Among Older Adults* recommends that anyone who is concerned about an older adult's drinking practices should ask direct questions. [20] Health care providers can preface questions about alcohol with a link to a medical condition when screening older people ("I'm wondering if alcohol might be the reason your diabetes isn't responding as it should").[21] Canadian practitioners have found that asking in a respectful and normative manner can positively affect how forthright people are. TIPS also recommends that every 60 year old should be screened for alcohol and drug abuse as part of his or her physical examination.

Some Points to Consider

- How can we better "normalize" talking about alcohol issues? To the general public? With older adults? With older adults who are already experiencing alcohol problems?

- What are the advantages and disadvantages to screening people above a set age, e.g. 60, for alcohol and drug abuse as part of his or her physical examination?

B. Assessment

There are two different ways of looking at alcohol as a problem:

1) alcohol is the problem (and you focus the assessment on the level of consumption);
2) alcohol consumption is an indicator of other problems or only one part of the problem.

Most agencies working with older adults generally take the second approach. TIPS suggests the need to look at substance abuse (what is the level and extent of the problem, what drugs are involved), functional impairments (ADLs and IADLs); cognitive dysfunction, medical status, sleep disorders, and depression. [22] Canadian agencies providing senior-specific services tend to go further in their assessments to get a clear idea of the challenges in the person's life and how those may affect the type of approach needed in offering assistance. They also stress the need to fully recognize and draw from the strengths and resources that an older adult brings. That may be: having stable housing, secure income, a supportive family, a good sense of humour, patience, good genes or any of the wide variety of other possibilities.

TIPS	Additional Considerations Being Used by Canadian Agencies
Substance Abuse	What is the level and extent of the problem, what drugs are involved,
Functional Impairments (ADLS and IADLS)	ADLs- how well can the person move around by herself or himself; bathing/ dressing/ hygiene; IADLs- the ability to meet the practical day to day needs- such as food preparation, housekeeping, shopping, traveling, finances- both the income source and management
Cognitive Dysfunction	Is the person's memory and ability to think being affected by the substance being misused or abused. Will the memory impairment change if the level of consumption is reduced or the person abstains?
Medical Status	A broad look at medical status, in addition to considering whether there visual and auditory problems
Depression	Mental health generally- attitude, appearance self direction, behaviours, affect, thought content perceptions, judgment
Sleep Disorders	Does the alcohol use interfere with sleep? Are there other conditions, such as pain, anxiety, or depression interfering with sleep?
Other	Nutrition- oral status, chewing/ swallowing problems, diet.

6. Best Practices in Treatment

A. The Need for Treatment

At present, very few older adults with an alcohol problem (possibly as low as 5% of those affected) receive formal help for it. This happens for several reasons. There can be an underlying ageism in the ways in which treatment and counselling resources are allocated, with the bulk of the funding going to the needs of younger adults. For example, if the underlying rationale or focus of addiction treatment is to help the person regain a "productive life" (and stay in or re-enter the work force), then older adults will be treated as a lower priority. If "years of productivity gained" are seen as the measure of the value of a program, then older adults' lives will automatically be given a lesser value.

Also, the negative effect of alcohol on older adults lives is often minimized or rationalized by people ("its not really doing any harm, besides what else does she to look to forward to?")[23] When some form of help is finally offered, it is often "late in the game" when the senior's health has already been seriously compromised. For the senior, the result often is a loss of personal autonomy and independence, illness, disability or in some cases, premature death.

People are often unaware that older adults experiencing alcohol problems respond well to help that is offered in an appropriate manner, that their chances of recovering from an alcohol problem are often better than younger adults, and that there are many different ways people can help a senior diminish the risk of a problem arising or recurring.[24]

Some Points to Consider

- Do all older adults who have an alcohol problem need treatment (e.g. support groups, counselling, detoxification)?
- At what point do older adults see formal help as necessary? At what point do others in contact with them see formal help as necessary?
- What are some of the common expectations of what alcohol treatment can accomplish for adults generally? For older adults in particular?

B. Seniors' Health and Treatment

Before discussing what the best practices in treatment are, it may be helpful to take a step back and place treatment into the broader context of the health and social situation of older adults likely to be coming to the attention of addiction services and other community services.

A 1998 study looked at the health profiles of 463 seniors who had been referred to an outreach program over a five year period. The study compared these client profiles to two other surveys of aging: (a) a large scale study called the Health and Activity Limitation Survey (HALS) which examines "normal aging" among seniors and (b) a sub-sample of over 5,000 people aged 55+ interviewed for the 1994-95 National Population Health Survey.

Fifty-five per cent of the program's female clients and 70% of their male clients were under 75. The clients represented all economic and social classes of seniors. This was not a random sample of older adults with alcohol problems, because a significant proportion of the referrals to the program come from the hospital or other health care settings. Nonetheless, the findings are very striking:

- only 3% of the older adults referred to the program were considered "healthy";
- 14% of the people referred had fractures;
- 15% (1 in 7) had experienced numerous falls;
- 1 in 5 was suffering from depression;
- 11% had cancer (2 ½ times the rate in the general senior population);
- 1 in 7 had a heart condition; 1 in 12 had a severe heart condition;
- 1 in 8 had a liver condition;
- 28% (or over 1 in 4) had noticeable short term memory problems;
- 1 in 3 (33%) had mobility impairments (trouble walking more than short distances, trouble climbing stairs, requiring a walker to get around, using a wheelchair), and
- 59% of the older women had mobility impairments.

Vision problems, cancer, respiratory problems, ulcers and cognitive impairment were much more common among the older adults with addictions problems than the general population over the age of 55 or even 75. These problems are also much more common among older adults with addiction problems than younger adults with addiction problems. Some of these conditions are simply more common among

older adults than younger adults. Others reflect the long term impact of high risk alcohol consumption.

Seniors and Health Study (Comparing the general seniors' population to seniors referred to SWAP- an alcohol and drug outreach program)

	HALS (a) or the National Population Health Survey (b)	The National Population Health Survey, for people aged 75+	SWAP clients (age 55+)
Cancer	4.2 % (b)	--	11%
Visual Impairments	5.9% (b)	12.3%	10% (often involving significant degree of impairment- macular degeneration, "legally blind", glaucoma etc)
Mobility Impairments	8.1% (b)	19.9%	33%
Chronic bronchitis, emphysema	5.7% (b)	--	12%
Stomach, intestinal ulcers	5.1% (b)	4.4 %(b)	14%
Cognitive impairments	--	--	28% (usually short term memory problems)

The majority of the clients had three or more significant health problems. The study found that alcohol problems seemed to accelerate "normal aging": if a certain health problem was common among adults generally at age 75 and over; then, it was evident even earlier among the addiction outreach program clients. These findings regarding health problems are quite similar to those found by the COPA program in Toronto in its 1995 evaluation.

Unfortunately many older adults who have alcohol problems do not have a family doctor or have not seen one for a long time. Some programs have found it very beneficial to have a physician formally connected to a senior's program, for several reasons. It can positively affect the health of

the client who has no doctor. Plus, it facilitates physician to physician discussions about the client needs, which can help avoid a family physician working in a way that might be at odds with the client's alcohol treatment plan and goals.

Some Points to Consider

- What are the key considerations affecting physicians behaviours with older patients when it comes to discussing alcohol matters?

- What are the best ways to provide information to and work with key contacts such as physicians? Are we finding certain ways do not seem to work?

C. Challenges and Strengths

Do all older adults who are experiencing an alcohol problem have health problems? Obviously not. It will depend on the current level of consumption, whether or not there has been binge drinking, how long the person has been drinking at a problem level, their gender, lifestyle (exercise, how well they eat), pre-existing health conditions etc. Nevertheless, knowing the negative health effects of long term heavy consumption, we should not be surprised to see many more health problems that will directly and indirectly have an impact on how treatment can and should be offered to many older adults. And health is not the only challenge.

Senior- specific programs frequently emphasize the importance not to be dissuaded by the fact that there are often many challenges. Instead they

- focus on clients' strengths,
- modify the pace of the work (much slower, smaller bites of information, repetition of information previously given),
- recognize that there may be a slower pace of change,
- divide larger or longer term goals into smaller achievable ones,
- reinforce client strengths and successes,
- arrange for clients to experience what it is like to feel well, or feel better
- adapt to the reality of the clients' lives.[25]

D. Barriers to Treatment

Many of the health conditions identified in the study leave an older adult temporarily or permanently disabled and can significantly affect the kinds of assistance the person needs as well as whether the person can access programs or services available in his or her community.

TIPS has identified four fundamental groups of barriers to treatment for people with disabilities:

- attitudinal barriers;
- discriminatory policies, practices, and procedures;
- communications barriers; and
- architectural (environmental) barriers.

These are very similar to the barriers that can be experienced by many older adults in accessing alcohol treatment services.

Some Points to Consider

Recognizing the health and mobility challenges that many older adults with alcohol can be experiencing,

- What are the physical and other barriers older adults face from the ways that counselling, residential treatment, and detoxification programs currently offer services?

- What steps are needed to reduce and eliminate those barriers?

- In what ways do the kinds of health problems being demonstrated by many older adults being referred to treatment necessitate a different approach than what is usually taken in addiction treatment (e.g. in counselling, residential treatment, detoxification)?

- How might memory difficulties affect an older person's ability to make changes in his or her life? Are there strategies from certain areas of gerontology that counsellors could build on to help meet these special challenges?

- What are the opportunities for cross training between disability and geriatric health service providers and substance abuse treatment

providers to help each other understand the impacts of aging, disability and substance abuse?

- What are ways to recognize older adults' strengths, while acknowledging the challenges they may be experiencing?

E. A Team Approach

In light of the fact there are often many complex issues needing to be addressed for an older adult experiencing an alcohol problem (and often, all at the same time), it is unlikely that any one person or program can meet all of these needs. There are important roles for family, peers, health care providers, mental health workers, seniors' centres, people who provide housing and many others to helping an older adult regain control over his or her life and achieve the maximum amount of independence possible.

F. Counselling

In the 1999 Canadian publication *Best Practices Substance Abuse Treatment and Rehabilitation*, the authors conclude that "intentionally brief sessions (up to eight sessions) appear to benefit socially stable, low to moderately dependent people with alcohol problems" (Guideline No. 10). They go on to state this short involvement is not likely to work for clients with multiple problems whose needs extend beyond those addressed by most intentionally brief intervention. This is particularly the case where there are mental health problems.[26]

In light of the fact that two thirds of older adults had an earlier onset for the alcohol problem, brief interventions (which tend to be a common approach in outpatient counselling in many jurisdictions) may be an unrealistic for many older adults. Senior specific programs often find that they will be working with clients for a much longer period of time than what is experienced in general addictions treatment for adults (six months to 2 years of information, counselling, support and relapse prevention, compared to a 6-8 week involvement). This reflects both more complex needs and the fact that problem has often been longer standing.

Some Points to Consider

- For which older adults does brief intervention counselling work?
- How can communities or service providers reach out to people effectively and hopefully "earlier in the game" so that they can benefit from approaches such as brief intervention?
- Will best practices in treatment be different depending on whether the problem is early onset or late onset?

G. Residential Treatment and Detoxification/ Withdrawal

Residential treatment provides counselling and other supports to a person away from their home, usually for a period of 28 days. It is often geared to people who are in crisis or need socially stabilizing interventions. Detoxification services provide people with a means to safely withdraw from the toxic effects of alcohol on their body. At present, there are major challenges in older adults being able to access and utilize both of these addiction- related services. In residential treatment it is largely because of

- the admission process (e.g. block admissions),
- the admission and the discharge criteria (e.g. not admitting anyone who needs prescription medication),
- pace and expectation of the service, and
- a lack of staff training on how aging affects addictions.

In detoxification services, there are often similar barriers, as well as the fact that most of the clientele are much younger people who are detoxifying from street drugs. As a result of the difficulties in meeting the detoxification needs within the community, at least three Canadian cities (Victoria, Vancouver and Toronto) have developed specific programs to help older adults withdraw from alcohol or other drugs safely. Each program functions in a somewhat different manner, with some stressing the home detoxification and others working to reduce the barriers that would otherwise exist in hospital detoxification or detoxification clinics.

Some Points to Consider

Recognizing the fact that typically there are very significant barriers to accessing residential treatment and detoxification,

- Should people be focussing on reducing those barriers or developing special services to meet the needs of older adults?

- If special services are developed for older adults, do they "fit better" within addiction services, health services or some other area?

H. Support Groups

Guideline No. 8 of the Best *Practices Substance Abuse Treatment and Rehabilitation* states that "consideration should be given to providing treatment in a group format unless otherwise contra-indicated." We are still in the process of learning how best to establish and maintain support groups for older adults (who feels comfortable in them and why), as well as learning what should be the goals of these group sessions. People are beginning to pose a number of questions about the structure and function of support groups hoping to identify "what works", including

- whether the groups should be mixed (with younger and older people; with older men and older women or only older adults of the same sex);
- what should be the purpose of the group (the addiction, or broader support goals)
- can different clients with different goals (abstinence, harm reduction) work well in the same group.

We are still learning about ways to tailor structured support groups to anticipate dropout and maintain participants. Other areas of health promotion offer some suggestions:

- incorporating a positive initiation component, a way of welcoming,
- making it "normal" for people to miss attending the group due to illness,
- developing a phone contact system to maintain involvement
- initiating a buddy system among participants,
- developing individual contacts to improve commitment

- incorporating more positive reinforcement strategies,
- supporting a social component (after group leisure activities) to promote cohesion in a group.

I. The Basics Requirements for Staff

No matter what area of treatment we are speaking of, it is generally recognized that it is important to [27]

- whenever possible, employ staff who have completed training in gerontology,
- employ staff who like working with older adults,
- provide training in empirically demonstrated principles effective with these clients.

Some Points to Consider

- How can mainstream programs in addiction build the skills of their counsellors to understand the needs of older adults?

- What are the basic requirements (in other words, how much training in aging issues is needed? And what types of aging issues)?

J. A Principled Approach

In other sensitive areas (e.g. mental health care), people have begun developing principles to guide the work that they do with older adults. Some of these principles may be useful, not only in considering treatment in the area of older adults and alcohol, but also in acting as a guide for community development and policy development.

The principles include

- ***being client centred*** (maintaining the dignity of older adults and treating them with respect; being culturally sensitive, recognizing the unique ethical issues that arise in the context of decisionmaking about care for older persons);
- ***orienting the goals*** of treatment to reducing the person's distress and improving or maintaining function and as much independence as possible;

- ***being accessible and flexible***;
- ***being comprehensive*** (taking into account all of their needs and working with other agencies to meet those needs);
- ***providing specific services*** that recognize the different needs between these adults and younger adults who have alcohol problems, and design the services that are appropriate and relevant to them
- ***being accountable*** - to the client, families and those providing services. [28]

7. Best Practices in "Special Populations"

A. Older Women

When people think of someone who might have a drinking problem, the image of the grandmother of three or the retired schoolteacher typically doesn't come to mind. As recently as the early1970s, people strongly believed that "nice women" did not go into bars, liquor stores, or wine shops. In the early 1970s, if a server in a restaurant asked an older woman if she would like a cocktail before dinner, in many Canadian communities, the older woman might have been offended by the question.

To many professionals, the possibility of alcohol becoming a problem for older women can seem unlikely. Yet many older women have developed a problem, and as progressive cohorts of younger women drinkers grow into old age, more women are likely to develop a problem.

Older men and older women experience different types of alcohol-related problems and in different ways. [29] For example, older women often feel and experience greater stigmas from friends, family and service providers not only about developing a problem with alcohol, but about drinking at all.[30] Alcohol problems can develop at lower consumption levels in older women than older men, and women are more likely to have combined alcohol-medication problems. Older women tend to drink in secret or in isolation, often hiding the problem until very late.

As previously noted, older women who have alcohol problems tend to have greater mobility impairment and other disabling conditions, making it physically more difficult for them to access help. Far fewer older women drive than older men, making access to programs and services and opportunities for socialization more difficult. For example, according to the

1991 National Survey on Aging and Independence, 92.4% of men and 80.6% of women aged 45-54 had valid drivers' licenses. However only 69.4% of men and 22.0% of women aged 75 and over did.[31]

Older women may have different life concerns than older men. Often, older women are caregivers to spouses or their own parents and need additional supports if they are to take part in activities outside the home. Poverty (or at least major changes in financial circumstances) is more likely to be a life stressor for women than for men, particularly at widowhood. Many people may not realize that 45% of "unattached" women aged 65 and over (in on the words, widowed, separated, divorced or single) live below the poverty line.[32]

Although some addiction programs have developed for women and their special needs, older women tend to be forgotten as part of that group. Somehow, they are moved from the compartment "women" to that for "seniors", losing their gender along the way. Even the very informative 1996 publication *Rural Women and Substance Use: Issues and Implications for Programming* (Ottawa: Office of Alcohol, Drugs and Dependency Issues), unfortunately makes no mention of the needs of older rural women.

Some Points to Consider

- Do older women need a different approach to education and treatment than older men? In what circumstances?

- What are ways of building the awareness of the special issues affecting older women into the work currently being done on "women and addictions"?

B. Older Adults Who Are Experiencing or Have Experienced Abuse

We know that alcohol is often a factor in family violence, so we should not be surprised to learn that it is also a factor in "elder abuse". In a 1995 literature review of over 550 publications on elder abuse, over 157 of them specifically identified alcohol as a risk factor for the abuse occurring.[33] This included physical, psychological and financial abuse as well as neglect). Sometimes the perpetrator (a son, daughter or other family member) had the problem); sometimes the older adult did.

In spite of this recognition that alcohol is an integral part of the violence or exploitation occurring, less than 3% of the interventions (types of assistance) being offered by adult protection agencies touch on the alcohol problem for either party. The simple issue is that elder abuse programs often do not know how to respond when there is an alcohol problem occurring, and addictions programs staff typically do not know how to recognize and address elder abuse situations. The two notable exceptions to this in Canada are the Victoria Innovative Seniors Treatment Agency (VISTA) in Victoria B.C. and the Seniors Well Aware Program (SWAP) in Vancouver, B.C.

However late life abuse is not the only abuse issue affecting the lives of older adults. Some older women who have drinking problems, much like younger women, have experienced abuse very early in life (so we may be seeing the longest term effects of childhood sexual or physical abuse). Counsellors may find that a 75 year old woman (or man) is telling them, possibly for the very first time in their life, about that early life abuse or spousal abuse that began when they were 20 and only stopped when their spouse died.

Some Points to Consider

- What are the opportunities for cross training in these two areas (elder abuse and addictions)?
- What are the training and support needs of addictions counsellors when they are assisting older clients who have experienced these types of abuse?
- What are the legal and ethical responsibilities of people in these circumstances?

C. Older Adults in Institutional Settings

Approximately 7% of older adults in Canada live in institutional settings. Those being admitted into care these days are often much older (85 years old on average) and more physically or cognitively impaired than people going into care even 15 years ago. Alcohol related health problems could be one of the many situations that can necessitate a person going into care. Part of this will depend on the older adults' health needs and

part will depend on the available community supports and services. For example, in Haldimand-Norfolk region of Ontario, the rate of institutional placement among older adults is 12.1%, compared to the provincial average of 4%.

Care facilities commonly purport that a) they are a place to provide for people's physical, psychological and social care needs and b) they are people's "homes". Those two identities and roles can lead to contradictory ideas about the role of alcohol in people's lives when they live in a care facility. Care facilities and other supportive environments seldom have any formal alcohol policies in place. This means that the gap will be filled people's own personal values around consuming alcohol, and particularly older adults drinking. As a result, older adults moving into or residing in a care facility may face several different types of problems related to alcohol consumption, including

- Being refused admission if the person who has an existing or even a previous alcohol problem,

- Forced abstinence ("no drinking" policy), whether or not the adults have ever had a problem,

- Alcohol being dispensed to an older adult at a nurse's station in a manner similar to dispensing medication,

- Invasion of personal privacy such as rooms searches for alcohol,

- Methods such as electronic surveillance to control them and their access to alcohol,

- Decisions around their consumption being made based on whether or not one is a "happy drunk".

At present, we still do not have a clear idea of the best approaches to policy development in this area. One facility in Edmonton ("Safehaven") has set aside one ward specifically for people who have alcohol problems, permitting them to drink as they wish. From a policy development perspective, we need to consider what are strengths and weaknesses of that approach.

Some Points to Consider

- How can we best approach policy development around alcohol policies in care facilities?
- What are the legal and ethical implications of the approaches we take?
- Where do alcohol policies fit into the broader discussion of older adults and risks? Who frames that discussion of risk?

D. First Nations, Inuit and Métis Communities

There has been considerable amount written on alcohol or other drug problems among young First Nations, Inuit and Métis people, but far less among older people in these communities. In some communities, older members help younger members deal with their addiction and act as model for a different way of living. But what if the older person has an alcohol problem?

We are still learning how to reach and help older members. In many instances, alcohol problem need to be understood in the context of social upheaval, loss of culture and roles for many older members. It can also reflect multi generational trauma, chronic stress, delayed / repressed grief resiliency and movement through grief. [34]

There are many important considerations in addressing alcohol problems among older First Nations, Inuit and Métis people. Older members in these communities live much shorter lives than the general population (a difference of about 12 years less on average). At present, older adults currently make up a relatively small proportion of the First Nations, Inuit and Métis population in Canada, and that means their needs may receive less attention. In 1996, just 4% of people who reported they were First Nations, Inuit and Métis were aged 65 and over, compared with 12% of general population.

As with the overall senior population, however, the number of First Nations, Inuit and Métis older adults is expected to grow rapidly in the next several decades. The Royal Commission on Aboriginal Peoples estimated, for example, that the number older adults among First Nations, Inuit and Métis people will almost triple between 1996 and 2016.

When an older person who is First Nations, Inuit or Métis has an alcohol problem, there often will be many challenges to providing help. Older members are the most likely group among to know and use a native language. In 1996, 35% of First Nations, Inuit and Métis older adults spoke a native language at home, almost 2½ times the figure for people in their communities under the age of 65. [35]

Certain health conditions such as diabetes are far more common in First Nations, Inuit and Métis peoples than in the general Canadian population. If not properly controlled, the diabetes can lead to problems such as peripheral neuropathy, poor circulation, and numbness of the feet. Alcohol problems can make it far more difficult to control the diabetes. The impaired mobility means people can become more isolated, and relying on alcohol more to deal with that isolation.

Another of the many challenges in these communities is what the most appropriate starting point is: abstinence or harm reduction. It has been noted that many key Native decision-makers and treatment staff take an abstinence approach.[36] That can be at odds with what the person feels is achievable, and if unable to remain abstinent, the person may feel as if he or she has "failed".

Some Points to Consider

- In what ways does being an older member of a First Nations, Inuit and Métis community affect the identification of an alcohol problem in that person's life? How do values of respecting elders affect the situation?

- How do older First Nations, Inuit and Métis adults view alcohol use as problem (spiritual, moral, health, other way)?

- Does the fact that alcohol is a "legal drug" affect the way it is responded to in First Nations, Inuit and Métis communities?

- When do older First Nations, Inuit and Métis adults view alcohol as problem in their own lives, in the lives of other around them?

- What are most effective ways of providing information and support on alcohol issues to older adults in First Nations, Inuit and Métis communities?

- What have people learned from working with younger First Nations, Inuit and Métis adults experiencing alcohol problems? Is that knowledge transferable to the older adults' situations?

E. Rural Settings[37]

Today, one in four older adults lives in a rural setting. [38] Many urban people tend to assume living in a rural setting means healthy living. However, harsher environments and rural occupations such as farming and primary industries (fishing, lumber, coal, mining, oil and gas) can leave older adults with special health problems. Add to that the reality that heavy drinking is often the norm in some communities, the potential for alcohol health -related problems to develop among older members of the community can increase.

When a person has an alcohol problem and lives in a rural community there can be many challenges that we may not see in urban settings. The closeness of many rural communities often means "everyone knowing your business", an older person with an alcohol problem may be more vulnerable to being stigmatized and ostracized, or conversely people may be more willing to "turn a blind eye".

Seeking services and offering services can be hard in rural communities. People may be reluctant to be seen going into a building where services for sensitive or stigmatized issues (such as family violence, addictions or mental health) are offered. This is particularly an issue for people with a high profile in the community. In rural communities, because neighbours often know each other, there can be reduced privacy. That, in turn, can affect a service provider's ability to assure confidentiality to a person experiencing the alcohol problem.

Rural researchers describe four elements affecting in the ability to offer and receive help: availability, accessibility, attitude, and awareness. Rural communities frequently have an insufficient number of health and social service providers for the size of the area being covered. Available services may be difficult to reach because of topography, distance and lack of adequate or affordable transportation. Older adults may be less likely to turn to "institutional" or "professional" sources of help in the community, at least as a first resort. Additionally, an older adult may decline the existing services because of rural values stressing independence and self reliance. Older adults who are willing to use the service often find out about it very late, because of a lack of awareness of what is available within the community.

Other service barriers in rural communities include
- lack of telephone access to "learn what's out there to help me", and
- language barriers, as many older adults in rural areas do not speak English.

For example, in northern Saskatchewan and Manitoba, large proportions of older residents may speak only Cree or Ukrainian. The receptionists and service providers at the local agency often do not.

Some Points to Consider

- What are some of the strengths of rural communities that can be drawn upon to help addressing alcohol problem among older adults?

- What positive approaches have we learned about delivering health services in rural and remote communities? Is any of this knowledge transferable to the ways in which we reach and support older adults experiencing alcohol problems?

F. Older People Who are Homeless

Stable home environment is typically seen as pivotal to a healthy life. Unfortunately for many older adults, there is no stable place to live, and being homeless is an immediate reality or a strong possibility.

There are several populations of older people who are homeless or very "vulnerable" to becoming homeless:

- a 78 year old heavy drinker who is being evicted from his apartment, but because of his cognitive impairment he is unable to plan where to go
- the 63 year old man who has alcohol and mental health problems, his erratic behaviour often means that he is not paying his rent, or his building manager will be throwing him out because of his self destructive behaviour or his behaviour towards other tenants
- a woman in her late 50s or 60s who has lost her job, isn't eligible for retraining, isn't old enough for old age pension and can no longer pay her rent

- a 78 year old woman who has been thrown out of her house (dislocated) by her 35 year old daughter and son in law six months after she signed title of the house over them. Her benzodiazepine use has increased dramatically since this crisis.

For some people who are homeless or who are precipitously close to being without a home, alcohol has already been a problem in their life. For others, using alcohol or other drugs becomes an important way to deal with and numb the realities of life on the streets.

Some Points to Consider

- What are some of the attitudes about alcohol problems or homelessness that can affect the way we provide services to people who are homeless?

- What are the health needs and the housing needs of older adults who have an alcohol problem and who are homeless or close to becoming homeless?

- Are there harm reduction approaches that work well with older people who are homeless?

- Are older adults (and particularly those older adults with alcohol or mental health problems) being left out of policy development around homelessness?

- What are some of the ways of reaching and supporting older adults who are homeless?

- What are some of the services that need to be in place when an older adult is homeless? Are different kinds of supports needed depending on whether this has been a long standing issue or a new one?

- What are the types of services and supports that people need to make a successful transition from the street to a more stable and secure life?

- Can working with and providing information to building managers on older adults' alcohol issues and the available alcohol and

mental health treatment resources for be part of a homelessness prevention strategy?

G. Concurrent Mental Health Problems

At present, mental health problems among older adults are significantly under recognized (in a similar way that alcohol problems are). An active alcohol problem will make a diagnosis (as well as the treatment) of mental health problem in an older adult more difficult.

When the two problems are occurring at the same time and both have been identified, the response among many mental health services often is

- "We don't have any services for older adults"
- "We will not assist the person, until you (the addiction counsellor) have the alcohol problem under control."
- The problem is considered "not serious enough" yet (there is depression, but not "clinical depression"; there is high anxiety, but she's not suicidal at this point)

The practical result is that the older adult's mental health problem frequently goes addressed.

Research and agency practice indicates that many older adults (25-50%) experiencing alcohol problems are also experiencing mental health problems at the same time. [39] As noted earlier in the Seniors' Health Study, depression was common among many older adults who have drinking problems.

Addiction counsellors often struggle with determining what is an appropriate role for them in this area. Fundamentally, the best role is not to "become the mental health worker", but to notice signs and symptoms of indicators of underlying mental health problem, and try to help the older adult access the needed services.

The 1999 *Best Practice Substance Abuse Treatment and Rehabilitation Guideline*, No. 17 which deals with "Clients with concurrent mental health problems" stresses the need for "close liaison and coordination to enhance referral and case management need to occur among the respective specialized services and informal street level agencies in a community. Training is crucial, not only for staff of respective services, but also for social services... where these clients often present themselves."[40]

It is important to realize that even if the mental illness is recognized and is being treated with the appropriate medications and therapies, that does not necessarily mean that the alcohol problem will go away. However, in a person whose symptoms of depression are controlled, an alcohol problem may be easier to treat.

Some Points to Consider

- What are some ways of linking people offering addiction treatment to people offering mental health services?

- What are the current opportunities for cross-sectoral training between addictions and mental health services serving older adults? What is needed to enhance those opportunities?

8. Best Practices in Community Development

> Community development is the process by which a community decides collectively on its needs and develops strategies to utilize its collective power to meet those needs.
>
> *Ontario Community Development Association*

Throughout this paper it has been clearly demonstrated that alcohol does not become a problem for an older adult in isolation. It occurs in the context of many different types of stresses and changes that may have begun late in the person's life or much earlier. It is apparent that many different types of people see older adults who have or are in the process of developing an alcohol problem. Many different types of people have skills they can bring to help prevent the problem from developing or help address it if it does become a problem.

So how do people begin to tackle alcohol issues affecting older adults in their community? That is where community development comes in.

A community development approach ensures that people within a community define their own needs and come up with their own solutions.[41] It allows community programming to work with the unique combination of needs and assets of the whole community. A solution worked out by one community may offer valuable lessons for others

tackling the same problem. However, every community is different. One size does not fit all. Community development lends itself to prevention and "cures". Programs are more likely to last when a community development approach is used.

People who work in community development around alcohol issues stress the importance of

- Identifying the type of need being presented in the community,
- "Getting to know your community." [Who are the people affected, who serves or assists the person? Who is interested in collaborative ways of addressing the issues? It is important to know who are the players, and who has a vested interest] and
- Picking a project that is do-able, in order to build on success.

At present most community development in this area has not offered a strong role for older adults. As in many other areas of community development affecting the lives of older adults, it is important to consider how to involve older adults in leadership roles in this process: heading up a volunteer committee, contributing to decision making, setting priorities for funding, etc. It is also important to consider how to create opportunities for older adults to further develop leadership and advocacy skills in this area.

Some Points to Consider

- When addressing alcohol issues affecting older adults, who is "the community"? Who is a stakeholder? How do you determine that?

- What are some ways to develop an intersectoral approach to the issue in the community drawing on many people's skills including mental health, volunteer services (friendly visiting, Meals on Wheels, Wheels to Meals), hospital services, community health (for example CLSCs in Québec, Community Health Centres in Ontario), housing authorities (including building managers), care facility staff, etc?

- What are potential roles of older adults in the community development process?

- What are the best ways to work together as community partners to effectively meet the complex needs of individual older adults who have alcohol or other substance abuse problems?

- Is it possible to develop an integrated community approach, to avoid seeing alcohol as the full extent older adults' "problem" or to avoid framing older adults' alcohol issues as "belonging to a group of experts".

9. Best Practices in Policy and Research

Throughout this paper, a number of policy and research matters have surfaced. Research in this area is still very rudimentary and often fails to recognize the heterogeneity of older adults. The research on alcohol issues has not gone very far in terms of differentiating between young-old and old-old adults or between older men and older women. The research in special populations of older adults (such as First Nations, Inuit and Métis people, rural or homeless older adults, older adults with concurrent mental health problems, older lesbian women or gay men) who are experiencing alcohol problems is virtually non-existent. Without good research, policy decision-making either occurs in a vacuum or is based on people's preconceptions of how, when and why alcohol problems develop, and how they should be addressed.

There are important policy considerations that flow from alcohol issues affecting older adults. Some of these relate to internal policies within agencies or between agencies (micro level policies), and others are the broader (macro level) policies within major systems such as provincial or federal ministries responsible for health, addiction, and other services that set direction and/ or allocate resources.

Some Points to Consider For Policy

- Is the level of the harm of alcohol problems among older adults and the effect on individuals and society being properly recognized at a policy level?

- If it currently isn't, what are the forces that interfere with that recognition?

- What would good policy development in this area look like?

- What ways are there to monitor and/ or provide feedback on policy changes or planned policy changes in addiction and other

services affecting older adults that may affect their opportunities to access and receive service?

The challenge for the present and the future will be broaden our understanding of the effect of alcohol problems on older people's lives and the rest of the community.

ENDNOTES

[1] The American literature needs to be considered carefully in light of the differences in the way health and social services are delivered in the two countries. Very few Canadian programs (general or senior- specific) have been evaluated on how well they meet older adult's needs.

[2] Experience in Action: Community Programming for Healthy Aging, Core Values

[3] Ibid.

[4] Hewitt, D., Vinje, G. & MacNeil, P. (eds.) *Horizons One: Older Canadians Alcohol and Other Drug Use: Increasing Our Understanding (*Health Canada: Ottawa), p. 10.

[5] *(1997)* A Portrait of Seniors in Canada *(2nd ed.) (Ottawa: Health Canada) Cat. No. 89-519 XPE, p. 80*

[6] Supra, n. 4, p. 14

[7] While some telephone surveys place the problem as low as 1%, the alcohol literature recognizes the strong likelihood of under-reporting among older adults and generally estimates that 6-10% of older adults develop a problem around drinking. Some estimates place it at 10-15% (see Philion J. (1988*) Substance misuse in the elderly* (Province of British Columbia, Ministry of Health.) Single, E., et al note that 9.2% of adults in the general population acknowledge alcohol has been a problem at some point in their lives. Single, E., McLennan, A, & McNeil, P. *Horizon, 1994 Alcohol and Other Drug Use in Canada* (Ottawa: Studies Unit, Health Promotion Directorate, Health Canada & Canadian Centre on Substance Abuse).

Two reports note that even where there are senior specific programs available, only 1-5% of the clients being referred to adult addiction programs are older adults :

- Michigan Dept. of Public Health (1993) *"The Best is Yet to Be": Substance Abuse Services for Older Adults*. (The Dept.: Lansing, Michigan) p. 18 and
- Alcohol and Drug Services (B.C), (June 1994) *Report on Older Adults and Alcohol Misuse* (Victoria, B.C.: Alcohol and Drug Services Prevention and Health Promotion Branch, Ministry of Health and Ministry Responsible for Older Adults)

[8] See: C.M. Gaitz & P.E. Bayer (1971) "Characteristics of elderly patients with alcoholism" *Archives of General Psychiatry*, 24, p. 372+; Tabisz, E, Badger, Meatherall, R. Jacyk, W., Fuchs, & D. Grymonpre (1991). "Identification of chemical abuse in the elderly admitted to emergency" *Clinical Gerontologist,* 11 (2) 27-38. For a review of the literature, see Stall, R. (1987) "Research issues concerning alcohol consumption among aging populations". *Drug and Alcohol Dependence* (19) 195-213.

[9] See for example: "Alcohol & Seniors" full text at http://www.ghc.org/health_info/self/seniors/alc_srs.html and Willenbring, M. & Spring, W. (Summer 1988) "Evaluation alcohol use in elders" *Generations*, 27-31.

[10] Older adults taking medication, (No. 48). http://www.hc-sc.gc.ca/seniors-aines/pubs/factoids/en/no48.htm

[11] Adams, W. (1996) "Interactions between alcohol and other drugs" in A.M. Gurnack (ed.) *Older Adult's Misuse of Alcohol, Medicines and Other Drugs* (Springer Publishing) 185-203. The effect is more pronounced for women

[12] Adapted by Canadian Mental Health Association, Ontario Division, from Telling is a Risky Business: Mental Health Consumers Confront Stigma, by Dr. Otto F. Wahl. 1999, Rutgers University Press. See: http://www.camh.net/foundation/foundation_news_spring2000.html#10%20Ways%20to%20Fight%20Stigma.

[13] For example, the Canadian Society of Addiction Medicine recommends discontinuing the use of the terms "alcoholic" and "alcoholism" because the terms are too imprecise. See Definitions in Addictions Medicine. http://www.csam.org/

[14] Canada's Seniors (No. 9) Educational Attainment and Literacy Level. http://www.hc-sc.gc.ca/oldseniors-aines/pubs/factoids/en/no9.htm

[15] In 1996, only 8% of all Canadians aged 65 and over had a university degree, compared with 17% of people between the ages of 25 and 64. Older adults were also less likely than their younger counterparts to have a certificate or diploma from a non-university post-secondary institution.

[16] Paul Roberts and Gail Fawcett. *At Risk: A Socio-Economic Analysis of Health and Literacy Among Seniors.* Centre for International Statistics, Canadian Council on Social Development. http://www.statcan.ca/english/freepub/89F0104XIE/high3.htm

[17] Communicating with Seniors: The Senior Audience, http://www.hc-sc.gc.ca/seniors-aines/pubs/communicating/audience_e.htm

[18] See the International Adult Literacy Survey.

[19] For example, the Alberta Consumer Health Information Society The Health Line in message 3302 on Drugs and Older People states:

> "On average, seniors drink less alcoholic beverages than younger people. But they are more sensitive to the effects of alcohol. That's because the body's ability to process alcohol decreases with age. Also, seniors are more likely to use prescription drugs, which can be harmful when mixed with alcohol. Even comparatively small amounts of alcohol may affect an older person's memory and ability to take care of him or herself. That person may not be able to live independently and instead require care in an institution."

If the person takes these statements literally (which is more common when the person has an active alcohol problem or a cognitive impairment), the phrase "when mixed with alcohol" can be confusing. It seems to suggest that there is only a problem if the drug is taken in or with the alcohol. The second paragraph seems to imply that that older adults drinking small amounts of alcohol will need to be institutionalized. That is not realistic, or accurate.

[20] (1998) *Substance Abuse Among Older Adults* , Treatment Improvement Protocol (TIPS) Series, No. 26, Frederick Blow, Consensus Panel Chair, TIPS Executive Summary, xviii. Substance Abuse and Mental Health Administration.

[21] Ibid.

[22] Ibid.
[23] Alcohol and Drug Services (B.C), supra, n. 7, p.10
[24] For example, in 1997, the Seniors Substance Use Network (SSUN), Central East Region in Ontario made a number of recommendations including the need for best practices identification and community development integrating, among others, front line workers who work with seniors, visiting homemakers, and pharmacists in helping address the problem (See: http://sano.arf.org/centeast.htm#draft).
[25] Bergin, B,. & Baron, J. (1992) LESA A Program of Lifestyle Enrichment for Older Adults with Alcohol and Other Psychoactive Drug Problems (Centretown Community Health Centre, Ottawa)
[26] Roberts, G. & Ogbourne, A. *1999 Best Practices Substance Abuse Treatment and Rehabilitation* (Ottawa: Office for Alcohol, Drugs and Dependency Issues), p. 29
[27] Supra, n. 19.
[28] See Appendix A, developed by Dr. Marthad Donnelly, Vancouver, 2000.
[29] See: Kunz, Jean Lock, and Kathryn M. Graham. "Life course changes in alcohol consumption in leisure activities of men and women." *Journal of Drug Issues* 26, no. 4 (1996): 805-829; Spencer, C. "Dispelling the Last Pleasure Approach: Older Women and Alcohol". Poster presented at Canadian Association on Gerontology, Calgary, October 23-26th, 1997; Spencer, C. *Understanding the Stigma of Alcoholism Among Seniors* (February, 1997) *GRC News 15* (4) 5-6; (1993); SHARE Family & Community Services. (1993) *Identifying and Responding to the Needs of Ethnic Women and Seniors in the Tri-City Area* (Ottawa: Health & Welfare Canada Health Services and Promotion Branch.
[30] See Anderson EG (Feb. 1991) "These foolish things: reflections on older smokers and drinkers. Geriatrics, 46(2): 71-2, 74. Spencer, C. (February, 1997) "Understanding the Stigma of Alcoholism Among Seniors" GRC News 15 (4) 5-6.
[31] Statistics Canada, 1991 National Survey on Aging and Independence, Catalogue No. 91M0002XDB. See also Seniors behind the wheel, Statistics Canada, *The Daily.* Thursday, September 9, 1999.
[32] National Council on Welfare, Poverty Report, 1998, p. 29. Also available online. www.ncwcnbes.net/htmdocument/reportpovertypro98/poverty98.html#_Toc500047787
[33] Bradshaw, D. & Spencer, C. (1999). The role of alcohol in elder abuse cases. In J. Pritchard (ed.), *Elder Abuse Work: Best Practice in England and Canada (*pp. 332-353). London, Eng.: Jessica Kingsley.
[34] Diabo, R. Physical and Psychosocial Environment. *Partners for Action: a Canadian Workshop on Seniors and Medication, Alcohol and Other Drugs*, January 9-11, 1995, Ottawa.
[35] Canada's Senior (No. 15) Aboriginal Population. http://www.hc-sc.gc.ca/seniors-aines/pubs/factoids/en/no15.htm
[36] Erickson, P. (1992) Implications of Harm Reduction for Substance Abuse Problems of Native People. Presented in Aboriginal Substance Use: Research Issues Proceedings of a Joint Research Advisory Meeting, Canadian Centre on Substance Abuse and National Native Alcohol and Drug Abuse Program.
[37] This is adapted from Abuse and Neglect of Older Adults in Rural Communities by C. Spencer, GRC News, May, 2000, Vol. 19, No. 1.
http://www.harbour.sfu.ca/gero/grcnews/grcn0005.html#spencer
[38] Health Canada. Division of Aging and Seniors. (1999). In cities, towns and elsewhere (Canada's Seniors, no. 16). [www.hc-sc.gc.ca/seniors-aines/pubs/factoids/en/no16.htm]
[39] Graham, K., Saunders, S., Flower, M, Birchmore Timney, C., White- Campbell, M., Pietropaolo (1995) Addictions Treatment for Older Adults (New York: Haworth), p.84.
[40] Supra, n. 25

[41] (1995) *Community Action Resources for Inuit, Métis and First Nations* (Ottawa Health Canada)