1. Project information

Fellow	Simon Ruth
Project Title	Developing a model of community based alcohol and drug treatment for an ageing population
Area of Study	Access/Mental Health
Fellow Organisation	Peninsula Health
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Report Date	18 July 2008

2. Project summary

Rationale/purpose of the project

- Statistics demonstrate that older adults are reluctant to attend alcohol and other drug (AOD) treatment.
- Proportionally, in the 2008-09 year, the Southern Metropolitan Region had more 8-11 year-olds attend AOD treatment than people over the age of 70 years.
- In 2006, 25.5 per cent of the Mornington Peninsula population was over the age of 60 years compared with 8.3 per cent of the population that was 12-18 years. By 2021, it is predicted 30.2 per cent will be over 60 years compared with 7.4 per cent in the key adolescent age group. Older age has a much greater impact on the local health dollar than the adolescent age group, yet there are at least five EFT (equivalent full-time) staff targeting adolescent substance use and none specifically targeting older adults.

- Both the United States of America and Canada have developed local older person specific AOD treatment responses that have seen a marked increase in the number of older adults attending AOD treatment.
- The purpose of this project was to investigate older adult specific treatment and determine its viability as a local service initiative.

Top three outcomes

- Confirmation that older adults are a hidden population of alcohol and drug users and that they will enter into treatment when it is tailored to meet their needs.
- Development of a network of professional relationships with other AOD services that have an interest in older, adult specific service provision.
- Witnessed a wide variety of treatment approaches with each designed to cater to local issues and needs.

Main activities undertaken

- visited 13 services that provide AOD treatment and prevention specifically targeting older adults
- visited four additional residential services that provide mixed age treatment responses
- participated in the Hanley Center's Professional's In Residence Program
- met with older adult's undergoing AOD treatment.

Major learnings

- There is a wonderful diversity of older adult specific AOD treatment programs from which Victoria can model service responses.
- There are many passionate professionals prepared to support Victoria in responding to older adult AOD issues.

- The Victorian healthcare system has all the necessary components to be able to provide effective and quality AOD treatment to older adults. The Victorian AOD sector understands the philosophy of providing flexible targeted responses and is experienced at providing tailored holistic responses to sections of the community that require them, for example, youth AOD services and Koori AOD services.
- Spirituality has a key role to play in AOD treatment for older adults as it assists older adults to understand their place in the world and find hope for the future.
- More so than any other age group, it is important for older adult AOD programs to have strong links with medical and mental health services. Staff in these programs require the ability to be able to recognise, respond and manage complex health issues.
- The author also learnt about the use and impact of crack cocaine on drug users, of which he had no previous professional experience.

Lessons for the Victorian healthcare system

- Older people do experience significant preventable AOD issues.
- Older people prefer, and are more likely to attend, older person specific treatment options.
- AOD staff require training and support to undertake effective AOD treatment with older adults.
- It makes economic sense to fund AOD treatment, and early intervention, in order to prevent hospital presentations and reduce the impact of AOD on disability adjusted life years (DALY).
- Older adults create many opportunities for Victorian AOD services to work in partnership with other sectors.

Background

Older people are under represented in AOD treatment. Physiological changes and increased isolation put the elderly at increased risk of developing substance use issues and being particularly vulnerable to their deleterious effects. Academic literature widely recommends developing older person specific treatment options.

Currently in Victoria, there are no services specifically targeting older persons for treatment or offering treatment options designed to support older people.

This project will investigate those services in the United States of America and Canada which do provide older person specific treatment options. The project will visit services in Florida, California, Vancouver and Toronto which have been identified as leaders in providing treatment services to older people, in order to establish what makes an effective older persons treatment service, how these are different to generic services and what staffing skills are required to provide the service.

The project seeks to address a number of key investigation questions grouped into four areas:

Access

How can services engage older persons in alcohol and drug treatment? How should services promote alcohol and drug treatment to older people? How can services create access to treatment for older people?

Treatment

What constitutes age appropriate and effective alcohol and drug treatment for older persons? How does older person specific treatment differ from general adult drug treatment?

Contributing Factors

What factors assist older persons to change their drug using behaviours? What impedes treatment effectiveness? What complimentary services support this?

Workforce

What skills and knowledge do treatment staff require to be able to effectively engage and treat older persons problematic substance use?

3. Description of the study itinerary

Thirteen primary sites across the United States of America and Canada were visited through the Victorian Travelling Fellowship. Selected sites each had expertise in the treatment or identification of older adults' alcohol and drug disorders.

3.1 Sites visited

Canada

Ontario

- Community Outreach Programs in Addictions (COPA) – Toronto
- Older Wiser Lifestyles (OWL) – City of Hamilton – Alcohol, Drug and Gambling Services

British Columbia (BC)

- Seniors Well Aware Program (SWAP) – Vancouver
- Victoria Innovative Seniors Treatment Approach
  Vancouver Island Health Authority – Victoria
- Abbottsford Community Services - Abbotsford, BC – Seniors Liaison program

- Four examples of residential services which take older adult referrals: Chilliwack Detox, Mapleridge Men's Treatment Centre, King Haven Men's Treatment Centre, Peardon Women's.

United States of America

Florida

- The Hanley Center, West Palm Beach
- The Florida BRITE Project - BRief Intervention and Treatment for Elders – Orlando
- Center for Drug Free Living – Orlando
- Broward County Elderly and Veterans Services – Fort Lauderdale
- Jackson Memorial Hospital – Miami

California

- Curry Senior Center - Substance Abuse Program – San Francisco
- Community Awareness & Treatment Services Inc. (CATS) - Golden Gate for Seniors Program – San Francisco
- St Mary's Center – Recovery 55 - Oakland

3.1.1 Community Outreach Programs in Addictions (COPA) – Toronto, Ontario, Canada

Key contact:

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Service description

Established in 1983 in West Toronto, COPA is an independent non-government community service organisation whose major activity is the provision of AOD services to people over the age of 55 years. COPA is government funded and employs ten staff. There are five EFT who provide outreach AOD treatment to older adults across the greater Toronto area. Outreach workers generally carry caseloads of 25-30 clients. The program was established around three major principles:

- outreach services should be provided rather than assuming older adults would attend office based services
- clients need not 'acknowledge that they have an AOD problem' to benefit from service
- services should support older person's independence and the maintenance of independent living.

Twenty-five years on, COPA still adheres to these key principles, although the language of harm reduction has advanced to better explain the benefits of treatment outside of a pure abstinence focus.

COPA employs eight staff, including administration, and provides 250-300 episodes of treatment per year. COPA provides a range of services:

- AOD outreach
- AOD group work
- health education
- volunteers program
- capacity building and secondary consultation
- Polish and Spanish language services.

COPA's clients often live in subsidised housing or assisted living centres. COPA also works with the homeless population through refuges and endeavours to focus its services on older adults who

are more isolated. COPA reports emerging issues around providing appropriate services to older adults who are gay, lesbian or transgender, particularly those who are transgender. COPA undertakes client satisfaction surveys once per year. Average client age is early to mid 60s although this is starting to flatten out with more clients appearing in their late 50s and in their 90s. COPA generally excludes referrals under 55 years.

Presenting substances of choice (in order): alcohol, prescription medication, cannabis and methadone.

Activities undertaken:

- attended staff meeting/focus group and morning tea
- met with Executive Director, Robert Eves.
- met with case worker, Horatio, regarding COPA College
- shadowed client home visit with case worker, Tobie.

Wish list

Ideally COPA would be three times its current size to meet the community need. Due to funding constraints COPA is unable to provide vehicles and staff either utilise their own cars or public transport. This can be time consuming and stressful, especially in a Toronto winter. It would be COPA's preference to be able to provide vehicles for staff use. COPA is currently unable to provide brokerage dollars to cases and believes this would be beneficial.

COPA report that inpatient withdrawal services in their jurisdiction are not older adult friendly and that many older adults are assessed as inappropriate. Ontario does not provide medicated withdrawal within its publicly funded withdrawal services.

COPA Client profile

Katherine is 77 years of age. She lives rent free with a housemate she met whilst in residential treatment 30 years ago. She feels safe in the housing despite reporting her housemate's erratic behaviour related to his own mental health issues. She suffers anxiety and depression and is treated with an antidepressant. She recently started drinking again after 20 years of sobriety. She has trouble sleeping as her housemate is often very noisy at night. She has two adult daughters who do not like to visit due to the housemate. At the time of meeting she had not left her house in 12 weeks as she is unsteady on her feet in the snowy/icy weather. Katherine's goal is abstinence. Her treatment focuses on identifying her triggers and alternative coping measures. Her outreach worker is also assisting with sourcing alternative accommodation so that her family will visit more often. Katherine stated that she would be unable to attend an office based service and thinks that it is good that COPA has expertise in servicing older people.

3.1.2 Older Wiser Lifestyles (OWL) – Alcohol, Drug and Gambling Services – Hamilton, Ontario, Canada

Key contact:

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Service description

The Older Wiser Lifestyles (OWL) program is part of a larger addiction service (ADGS) operated by the City of Hamilton. ADGS has a total of 17 staff who provide outpatient counselling. ADGS has one primary site from which all services are delivered, plus two off-site locations which provide assessment and referral for treatment. The OWL program has a lone worker who focuses on providing treatment to older people. OWL provides:

- one-to-one counselling
- seven week education group that focuses on transitions such as retirement, loss and lifestyle change
- two gender specific support groups.

OWL provides both office based counselling and outreach, although outreach is limited. The average age of clients is early retirement and there are older clients with late onset AOD issues due to grief and loss. Ms Franklin believes there is a class bias in the client group and believes this would be eliminated if she offered more outreach.

OWL has established a committee amongst like minded services locally to promote older adult AOD issues and develop joint responses, as a sole worker in the Hamilton area is unable to meet the need.

Presenting substances of choice: alcohol, medications, cannabis and some crack use.

Activities undertaken:

- shadowed OWL Counsellor, Bonnie Franklin
- met with Program Manager, Debbie Christie
- attended men's group.

Wish list

OWL cited the Lifestyle Enrichment for Senior Adults (LESA) in Ottawa as their ideal service response. Ottawa is of a similar size to Hamilton. LESA has six multidisciplinary staff providing AOD outreach, counselling and group work for older adults. LESA exists within a broader organisation with good access to medical and psycho-geriatric supports. LESA serve meals to promote nutrition and operates community kitchens. LESA jointly facilitate a number of relevant clinics such as diabetes and podiatry clinics.

OWL offices are upstairs in an office building. Non-ambulant clients may have difficulty accessing services and the preference would be to be located in a more accessible location.

The OWL Men's Group

The men's group was attended by seven participants and facilitated by Ms Franklin, with a student in present. The men's group usually features a round the room check in and a topic for discussion. The topic for discussion for this day was 'What is good about having an older men's group?' The men have mixed goals from moderated drinking to abstinence. Many have attended a range of treatment and support options. The group is run fortnightly.

The points raised amongst the group were:

- *The men like being in a group of similar aged people as they have similar interests and issues.*
- *They like being able to discuss health concerns related to ageing.*
- *The men particularly like this group as it has a less dogmatic approach and promotes harm reduction as well as abstinence approaches, such as Alcoholics Anonymous.*

- *Many younger people are forced into treatment which affects group dynamics, unlike this group where everyone wants to be there.*
- *The men like being in a men only group as it allows for discussion of sexuality and men's issues.*
- *Group members are more mature and respond appropriately to each others issues.*
- *Would like the group to meet more often.*

3.1.3 The Florida BRITE project

Key contacts:

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Project description

The mission of the Brief Intervention and Treatment for Elders (BRITE) project is to serve individuals 55 years and older to identify non-dependant substance use or prescription medication issues and to provide effective service strategies prior to their need for more extensive or specialised substance abuse treatment. Once identified as at risk for developing AOD issues, participants are offered brief interventions (one to twelve sessions) of health education and strategies to avoid the need for specialised treatment. Florida BRITE

funds a range of services to conduct screenings and provide interventions across the state.

BRITE is based on a model of screening, brief intervention, and referral to treatment (SBIRT) and is funded by a $14 million grant from the Center for Substance Abuse Treatment of the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Florida Department of Children and Families Substance Abuse Program Office. The grant focuses on primary and emergency health care settings, public health clinics, and aging services. Clients may be offered screening, brief intervention, and brief treatment by these generalist providers or they may be offered more intensive care by a substance abuse specialist provider agency.

In addition to medical settings, BRITE screens and provides brief interventions in aging services, retirement communities, senior housing, at health fairs, and at other locations. This population is a high priority age-group in Florida, given that Florida has the highest median age population among all states in the USA.

BRITE is undertaking a six-monthly follow up linked to random selection via social security numbers.

Activities undertaken:

- meetings with Bob Hazlett and Vance Burns
- visits to three BRITE sites – The Center for Drug Free Living (Orlando), Jackson Memorial Hospital (Miami) and Broward County Elderly and Veterans Services Division (Fort Lauderdale).

BRITE Site 1

The Center For Drug Free Living Inc (CFDFL) – serving Orange, Seminole, Osceola Counties

Key contact:

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Service description

The CFDFL is a comprehensive, community-based, substance abuse treatment and prevention agency serving the residents of Central Florida, regardless of age, sex, race, creed or ability to pay. Serving the Central Florida community with quality human services for over 35 years, The Center For Drug-Free Living has developed a diverse regimen of treatment, intervention and prevention services to help its clients develop healthy and responsible lifestyles.

In addition to operating as a BRITE site the CFDFL provides outreach AOD treatment. The CFDFL began providing alcohol education targeting older adults in 2001. Following this there was a call for similar education targeting medication mismanagement for older adults. BRITE funding was received in 2005. CFDFL are investigating incentive payments to hospitals and GPs for referrals.

Presenting substances of choice: alcohol, medications, illicit use (less common but increasing).

Activities undertaken:

- met with Frank Vande Loo, Director Prevention Services and Victoria Adams, Program Director – Older Adults.

Wish list

CFDFL would like increased treatment funding. CFDFL would like to promote cultural change to make it okay for older adults to discuss alcohol problems.

BRITE Site 2

Jackson Memorial Hospital (JMH)

Key contact:

Elena Quevedo, Project Coordinator
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Miami, FL 33136-1038

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Service description

Jackson Memorial Hospital (JMH) is a non-profit, tertiary care teaching hospital and is considered as one of America's finest hospitals. With more than 1,550 beds, it is the third-largest public hospital and third-largest teaching hospital in the United States.

The JMH Emergency Department is utilised as a BRITE site with two staff completing screening and offering follow up interventions to older adults who have attended the emergency department. Every patient over 55 years who attends during worker hours is asked to undertake a screening and offered designated follow up.

In addition to its BRITE program, JMH also operates an AOD residential withdrawal service. The BRITE facilitators are employed

by the hospital social work department. Operating from an emergency department, patient retention can be an issue. Staff attempt to follow up through next of kin and may conduct telephone sessions for follow up if patients unable to re-attend. JMH is planning to extend its current BRITE delivery hours. JMH is reporting strong take up by older adults of interventions offered and subsequent downward pressure on hospital resources.

Presenting substances of choice: alcohol, medications, cannabis and, less frequently, illicit drugs, primarily heroin and cocaine.

Activities undertaken:

- met with Claude Francois, JMH Quality Department
- met with BRITE facilitators – social workers Grace and Barbie
- toured JMH Emergency Department.

BRITE Site 3

Broward County Elderly and Veterans Services Division (BCEVD)

Key contact:

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Service description

Broward County Elderly and Veterans Services Division (BCEVSD) provide a range of services for seniors similar in many ways to the types of services provided by Victorian local governments. Services

include case management, home help, personal care, adult day care, respite, outreach and referral. Broward County received BRITE funding in 2004 following identification of the need to provide AOD services to older adults.

Broward County also operates an AOD service, the Broward Addiction Recovery Center (BARC). BARC had operated the Mature Adults Program, which provided office-based counselling to older adults, but this service is being scaled back due to lack of take up. The two services operate independently of each other.

BCEVSD began servicing older adults' AOD issues as no other service would take the referrals or provide the necessary outreach service provision. Older adult AOD services began in 2002, initially with prevention programs and then outreach treatment services in 2003.

BCEVSD service a population of 350,000 older adults with ten staff (four outreach/counsellors, two prevention workers, one case manager and the project supervisor).

Presenting substances of choice: alcohol, medication misuse and increasing use of illicit drugs, particularly cocaine.

Activities undertaken:

- met with Divisional Director, Stephen Ferrante
- met with BRITE Project Supervisor, Raul Gordillo
- met with program staff, Nico and Janet.

Florida – The Marchman Act

The Marchman Act is a law under the Florida Statute that enables family members to obtain help for a loved one who is unwilling to seek substance abuse services voluntarily.

The substance-impaired person must meet the following conditions:

- *Has lost the power of self-control with respect to substance use; and EITHER*
- *Has inflicted or threatened or attempted to inflict physical harm on himself or another; OR*
- *Is in need of substance abuse services and, by reason of substance abuse impairment, is incapable of appreciating the need for such services and of making a rational decision in regard to receiving services. However, mere refusal to receive such services does not constitute evidence of lack of judgment with respect to the need for such services.*

The law allows for up to five days to complete the evaluation on a court ordered assessment. During that time the facility may ask the court for an extension, release the client, or file a petition with the courts asking for the judge to court order treatment services. The judge can court order an individual into services for up to 60 days.

3.1.4 The Hanley Center, West Palm Beach, Florida, USA

Key contacts:

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Service description

The Hanley Center is a not-for-profit private AOD treatment service formerly associated with Hazelden but now independent. The Hanley Center provides a range of services but the primary focus is its three residential programs: the Centers for Men's Recovery, Women's Recovery and Older Adult's Recovery. Each program can accommodate 20-30 people with an upper combined population of 82. Participants receive a medicated withdrawal and follow through to a 28 day, 12-step facilitated (Minnesota model) rehabilitation program.

The Hanley Center residential programs provide a holistic service where clients undertake comprehensive medical, psychological, psychiatric and spiritual assessments. The various facets of these are integrated into a joint treatment response. The Hanley Center also offers an outpatient aftercare program and follow up by the alumni care team. The alumni care team organise meetings of alumni across the country so that former residents can jointly support each other. Whilst in residence, participants are involved in a comprehensive program of individual and group sessions including physical activities in the wellness center. Families are provided weekend-long families program to assist them to understand what is occurring in the recovery programs and how they can support this.

Hanley reported little cultural diversity amongst its residents. Hanley prevention services provide older adults with medication bags and encourage them to take all their medications with them for each doctor's visit as they report older adults often do not fully explain their medications to doctors.

Activities undertaken:

- participated in four-day 'Professionals In Residence Program'
- met with Carol Colleran, who established the Older Adults Recovery Program
- buddied with a resident in Older Adults recovery Program for a half day.

Baby Boomers

Hanley reported they are considering developing a specific service targeting baby boomers. As the baby boomers enter old age they are forming a distinct group from the other older adults. Baby boomers are still clearly different from younger service users but they have different needs and wants to the previous generation. Baby boomers do not want to discuss the war. Baby boomers are more affluent than the other older adults. Baby boomers are happy expressing their needs and wants. They are more comfortable advocating for themselves or others. Baby boomers are less likely to respect the knowledge of the treatment service. Baby boomers have explored a greater range of drugs and may still use illicit drugs.

Wish list

Carol Colleran is well past normal retirement age. Carol said she is still working as she hopes to change sector attitudes towards treating older adults and wants to encourage others to take up the cause. At Hanley, she hopes to create a separate baby boomer program.

The Accidental Addict

Hanley reports that many of their older adult clients had no AOD issues in younger life and described them as accidental addicts.

Older people undergo significant physical changes and are more likely to be on a range of medications. With ageing we see:

- *Increase in body fat*
- *Decrease in body water content*
- *Decrease in gastrointestinal tract functions*
- *Decrease in albumin*
- *Decrease in liver function*
- *Decrease in kidney function*

These changes decrease the body's ability to process drugs including alcohol. If older adults continue established drinking patterns from their younger years they may find themselves developing serious AOD issues. This is further complicated by older adults use of prescribed and over the counter medications. Older adults are prescribed more medications than any other age group.

Two clear of older adults entering treatment for alcohol problems - those who experienced early onset alcoholism and late onset alcoholism.

Early Onset alcoholism is characterised by:

- *A long history of chronic alcoholism*
- *Early drinking age between 14-20 years*
- *High tolerance to alcohol that has increased over time*
- *Multiple attempts to quit, treatments and withdrawal experiences*
- *Family History more prevalent*
- *Cognitive loss more severe, less reversible*

Late onset alcoholism is characterised by:

- *Drinking problems began post 50 years of age*
- *Significant Transitions or loss late in life*
- *Increased toxic effects related to lower tolerance and mixture of medications*

- *Shame and grief*
- *Family History less prevalent*
- *Cognitive loss less severe, more reversible*

3.1.5 Victoria Innovative Seniors Treatment Approach (VISTA), Vancouver Island Health Authority – Victoria, British Columbia, Canada

Key contact:

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Service description

Victoria Innovative Seniors Treatment Approach (VISTA) offers outreach services to individuals 55 years and older who are experiencing problems related to alcohol or prescription drugs. These problems may occur along with late-onset mental health problems, neglect or abuse. VISTA counsellors provide consultative services, educational workshops and group counselling.

The VISTA was originally funded in 1989 and was based on the COPA model. It began providing services to nursing homes and now services the whole community with eight staff and a consultant medical officer. It was originally an independent organisation but was brought under the management of Vancouver Island Health Authority as part the government of British Columbia's rationalisation of AOD services, which saw many smaller AOD specific agencies defunded and responsibility handed over to health authorities. It now sits within the same management structure as

geriatric psychiatry. VISTA's catchment has a total population of 350,000 of which 20 per cent are over 65 years. Average age of patients is 70 years and they receive 200 referrals per year. VISTA report there is little diversity amongst its clients but this is changing.

VISTA has little contact with VIHA's other AOD services. VISTA believe it is more important to establish relationships with other older adults programs than AOD services.

Presenting substances of choice: alcohol, medications, small amounts of cannabis and cocaine.

Activities undertaken:

- met with Dr David Evans
- shadowed Dr Evans rounds in Geriatric Acute Psychiatry Unit
- attended older adults education group
- met with outreach workers Barbara, Jan and Des
- met with Guiseppe Scalletta, Program Manager VISTA and EOS
- met with Mary Catherine Collins, Manager Older Adult Mental Health and Addiction Services
- met with Dr Mike Cooper, Chief of Geriatric Psychiatry VIHA.

Wish list

VISTA would like to be able to focus more on tobacco. Research has shown that clients who cease tobacco use at the same time as their other drugs have better recovery outcomes.

VISTA stated that the lack of an older person specific residential rehabilitation and residential withdrawal units are major gaps in service provision. VISTA would like to see greater options for dry housing as many care facilities are wet.

3.1.6 Seniors Well Aware Program (SWAP) – Vancouver, British Columbia, Canada

Key contact:

Deborah Broadhurst, Executive Director
Suite 212, 309 West Cordova St
Vancouver BC V6B 1E5

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Email swap@123mail.org
www.swapbc.ca

Service description

SWAP is a non-profit society operated by a volunteer Board of Directors. SWAP has been serving older adults 55 plus for over 25 years. SWAP provides information and education to community groups, other service providers and family members for the purposes of prevention and early intervention and treatment planning. SWAP was funded in 1982 to provide a range of AOD treatment services for older adults. It originally utilised the COPA model. It continued to provide these services until recently when it was defunded as part the government of British Columbia's rationalisation of AOD services which saw many smaller AOD specific agencies defunded and responsibility handed over to health authorities. SWAP previously had ten outreach staff. Vancouver Health Authority replaced with a five worker, office based counselling service.

Activities undertaken:

- met with Deborah Broadhurst, Executive Officer.

Wish list

SWAP would like to the see the re-establishment of AOD outreach services for older adults in Vancouver. SWAP hope to facilitate a seniors developed and lead health education program about AOD issues for the pre-retirement population.

3.1.7 Abbottsford Community Services Seniors Liaison Program (ASLP) - Abbotsford, British Columbia, Canada

Key contact:

Sharon Hollingsworth, SLP Counsellor.
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Abbotsford, BC V2S 3S9

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Service description

Abbotsford Community Services, registered in 1969, is an interdependent, non-profit, multi-service, community based agency with a three-fold intent:

1. to plan for and provide direct social and community services
2. to raise and heighten awareness of social concern and priorities within the community
3. to create opportunities for community members to participate in serving, developing and strengthening their community through partnership with government, private organisations and individuals.

Abbotsford Community Services provides a range of community health and welfare services including AOD services, social support services, youth and family services and Punjabi community services. The Seniors Liaison Program provides assessment, active treatment, and after care to seniors, 55 yrs+ who are experiencing

alcohol and/or drug related problems. The program has one counsellor who is supported by the generalist AOD workers and the other seniors programs.

Presenting substances of choice: alcohol, medications, cannabis, crack.

Activities undertaken:

- met with Sharon Hollingsworth
- attended Women's Group
- shadowed Sharon Hollingsworth for a day
- visited four residential services to which the SLP refers: Chilliwack Withdrawal Unit (10 beds), Mapleridge Men's Treatment Centre (60 beds), Kinghaven Men's Treatment Centre (58 beds) and Peardon House (Women's) Treatment Centre.

<u>Residential services:</u> All residential services, within the Fraser Health Authority catchment, require a monetary contribution. This does exclude some clients, particularly older adults. Each service reported that the other clients benefit from having older adults present but that older adults tend to do better when they are not the only ones. The services reported that older adults require breaks from the normal schedule and can not participate at all levels particularly where there are work programs that rely on physical strength. It was reported that sometimes older adults have expressed feeling unsafe and disconnected from younger people whilst in the services. Each service stated that older adults may benefit from a more tailored service with more people their own age. The Chilliwack Withdrawal Unit has one dedicated bed for older adults.

Wish list

ASLP would like to be able to increase service provision to older adults and provide more outreach and flexible funding to be able to work more creatively with older adults. ASLP advocates strongly for older adult specific residential withdrawal and rehabilitation services.

The ASLP Women's Group

This was the initial meeting of the women's group. All the women were also in counselling and at various stages of recovery. This particular group operated as a morning tea with china, pastries and flowers. This set up acknowledges the women's stage of life and thanks them for attending. Each week one woman will get to take the flowers home. The initial group had four participants. The group will never be larger than six participants to ensure consistency for the participants and allow them to bond. The group aims to decrease isolation by allowing the women to share their experiences. The women each introduced themselves and discussed their reasons for being there as well as their recent treatment history. This way each woman had something of interest to group to discuss. The women were able to discuss their feelings about different treatment types. The women discussed the group rules and openly discussed that they would need to be sober to attend.

3.1.8 Curry Senior Center Substance Abuse Program (CSC). San Francisco, California, USA.

Key contact:

Vinita Lee
Clinical Supervisor, Substance Abuse Treatment Program

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Service description

Curry Senior Center is a non-profit organisation in San Francisco. It provides medical treatment, counselling, case management and meals to low-income and frail senior citizens who need assistance. The Center is in the heart of San Francisco's troubled Tenderloin district and services the city's most marginalised populations of older adults. A significant number of clients are homeless. The client group is very ethnically diverse and all services are free.

The service offers both office based and outreach services as well as groups. There are four staff who carry caseloads of 25-30 clients each. Clients stay in treatment from 6-48 months. Only one client in twelve months has presented with medication related AOD issues. This community can not afford medications. The average client age is 65 years.

Presenting substances of choice: poly-drug use, alcohol, crack, methamphetamine, heroin, methadone.

Activities:

- met with Vinita Lee
- toured service.

3.1.9 CATS - Golden Gate for Seniors (GGFS) - San Francisco, California, USA

Key contact:

Nicole Johnson, Counsellor
637 South Van Ness Ave
San Francisco

Phone 415 626 7553
http://www.careforhomeless.org/services/ggate.html

Service description

Community Awareness & Treatment Services, Inc. (CATS) is a private, non-profit organisation founded in 1978 to provide a continuum of care for people with drug and alcohol abuse problems. Over time, CATS evolved to specifically focus on helping the homeless in San Francisco, with the primary goals of promoting positive, lasting change and reducing street deaths. CATS focuses on the 'hardest to serve' homeless, those multiply diagnosed with chronic addiction, mental illness, physical disabilities, HIV+/AIDS, hepatitis C, tuberculosis, and other health problems, as well as veterans, survivors of domestic violence, sex workers/prostitutes, and transgenders in San Francisco.

Golden Gate for Seniors (GGFS) was established in 1987 and is a 20-bed residential recovery home specifically designed for chemically dependent men and women aged 55 and over, who have completed a primary substance abuse treatment program.

GGFS provides the setting needed to obtain a more meaningful life free from alcohol and drugs, promoting dignity and self value, and offering long-term housing and meals. Residents stay an average of six months in the centre while following an individually tailored recovery plan, which includes counselling and case management, 12-step meetings, education on alcohol and other drugs, sound health practices, and development of interests and activities that are conducive to a sober lifestyle.

The facility is located in San Francisco's Mission District, amidst a street drug trade and significant poverty. The facility has a large

number of stairs and is unable to accept older adults who are not fully ambulant or not functioning at a normal level. Clients must be abstinent for 72 hours prior to admission. GGFS has three full time and two part time staff. The basic program is in excess of 90 days with most residents staying for 12 months.

Presenting substances of choice: alcohol (70 per cent), crack (50 per cent), cannabis (rare), no benzodiazepines or medications. **Current primary drug on date of visit:** alcohol (55 per cent), crack cocaine (40 per cent), heroin (5 per cent). None reported a history of poly-drug use on day of visit. GGFS reported that crack use amongst its clients is steadily increasing.

Activities:

- met with Cyrus Carter, Program Coordinator
- met with Nicole Johnson, Counsellor
- toured service.

Wish list

GGFS facility is not wheelchair accessible and has a large number of stairs. GGFS would like to be able to relocate to a more appropriate building for older adults. GGFS would like to be able to offer an aftercare program and greater follow up for former residents. They would like to increase their staffing numbers to be able to offer around the clock support to residents. They would like to be able to offer in house mental health and medical services. GGFS would like to be in a neighbourhood without a heavy crack presence.

3.1.10 St Mary's Center – Recovery 55 Program (R55), Oakland, California, USA.

Key contact:

Pier Schwartz
Director Dual Diagnosis Program
925 Brockhurst St
Oakland, CA 94608

Phone 510 923 9600 x201
http://stmaryscenter.org

Service description

St Mary's Center is a non-profit non-government organisation dedicated to providing services and a voice for extremely low income seniors. St Mary's Center also provides services for low-income families and preschoolers in Downtown and West Oakland. St Mary's Center has been serving low income seniors since 1973 providing meals, crisis accommodation, financial aid, case management, AOD treatment services, home visiting, social inclusion programs and a drop in centre. The population served is 45 per cent African American, 35 per cent Caucasian, 14 per cent Pacific Islander/Asian and 6 per cent Latino. The Center is based in an extremely poor part of Oakland. Originally affiliated with a catholic parish, St Mary's Center was incorporated as an independent organisation in 1992 and now has no affiliation with the church.

R55 has eight outreach staff and ten seniors companions. Seniors companions are volunteers who receive a small stipend to undertake social engagement of isolated older people. The stipend covers transport costs of public transport. R55 describes itself as a dual diagnosis treatment program. Seventy- five per cent of clients have mental health issues and 100 per cent have AOD issues.

St Mary's advocated strongly for older people's rights to health and wellbeing. St Mary's discussed the United Nation's *Madrid Plan of*

Action on Ageing that outlines the rights of older people in society. St Mary's Center works hard to provide a voice for older people to engage in meaningful debate and policy advocacy on behalf of themselves. The Hope and Justice Program facilitate older people's engagement in public policy. St Mary's involves it's seniors in annual evaluation of its services.

In winter, St Mary's provides crisis accommodation in its drop in centre for 25 people per night. Older people's homelessness became a significant issue following 1989 earthquake which saw many cheaper residences get condemned.

St Mary's endeavours to provide a range of opportunities for older people to re-engage in their community. Carol Johnson reported St Mary's has a 93 year old volunteering in their preschool.

Ms Schwartz stated many seniors have been sitting at rock bottom for years. The sector needs to find a new way forward and a new language for older adults' addiction issues.

Presenting substances of choice: crack, poly-drug use, alcohol, heroin, cannabis, methamphetamine. No medication abuse as clients can't afford them.

Activities:

- met with Carol Johnson, Executive Director
- met with Pier Schwartz, Director Dual Diagnosis Program and Manager Recovery 55 Program
- attended Men's Recovery Group
- toured centre
- shadowed Pier Schwartz for the day.

Recovery 55 Men's Group

This was a facilitated group with 10 men in attendance. They were in various stages of recovery. Eight had a history of drug use and two had a history of alcohol only. The men asked about why they preferred to attend the Recovery 55 men's group. The men felt they did not learn from mixed age groups as young people tended to dominate and had nothing to offer older people. Some stated they felt unsafe in mixed age groups and that younger people may target them. Older person specific groups have a more relaxed atmosphere. Mixed age groups discuss employment, careers and child rearing which aren't relevant to older people. In older person's groups there is a joint wisdom which comes with age and participants share similar places in history and in recovery. Participants in older aged groups respect each others journey and opinions where as younger people tend to be dismissive of them. Younger people tend to be chaotic and have little understanding of past community attitudes and values towards drug use. Older adults can workshop solutions together and model behaviours for each other. They can help each other develop hope for the future as they have a better understanding of each others past.

Wish list

R55 would like to be able to offer greater linguistic diversity amongst its staff. R55 would like older person specific and sensitive residential withdrawal and rehabilitation services to be developed.

3.2 Discussion

Access

How can services create access to treatment for older people?
How can services engage older persons in alcohol and drug treatment?

How should services promote alcohol and drug treatment to older people?

It was widely accepted across all the services visited that older people require services tailored to meet their needs. Older people do not feel welcome in generalist AOD services, especially in group programs and residential services. Staff in generalist AOD services find older people difficult and tiring to work with. There is a common attitude amongst professionals and the community that older people should be allowed to have a few drinks if they want. Older people's AOD issues often go unnoticed or are misdiagnosed. Services can engage older people by acknowledging that older people require different pathways through treatment and by offering older person specific treatments or developing specific expertise within their services.

The services visited reported a number of ways that they promote AOD treatment for older adults and create access:

1. Acknowledge the issue

All the services visited developed older person specific options as a means of engaging older people in treatment. In every case it was recognised that there is a significant population of older people who have AOD problems that were going unaddressed. These people do not appear in health statistics as their drug issues are often misdiagnosed or not recorded. They do not attend treatmemnt as the treatments on offer do not meet their needs.

Professionals and community alike exhibit poor attitudes towards older people's AOD issues by looking the other way or minimising the issue. Granny's last pleasure is not a pleasure if it is

exacerbating her depression or creating health problems. Carol Colleran, of the Hanley Center, told of how she had to argue the case for the Center for Older Adult Recovery against others who said it would not be financially viable. Ms Colleran said they have not had an empty bed since its opening.

2. Develop relevant services

The services visited provided a range of residential services, centre based counselling and outreach counselling. Amongst the outpatient treatment services it was widely accepted that outreach service is best practise when endeavouring to provide a service for older people.

COPA, as the longest operating service, firmly believes in the provision of outreach AOD practise as a means to engage older people in their own environment. COPA sees office based services as inhibiting many older people's access. CSC, BCEVD, CFDFL and VISTA all provided outreach as their core reponse. R55, ASLP and OWL each provided a mix of office office based counselling and outreach.

Each service reported that providing outreach meant they could engage older adults who were unable to attend office based services due a range of reason such as poor ambulancy, anxiety or lack of transport. OWL particulalry expressed a wish to be able to provide greater levels of outreach as they believed it would diversify their client cohort which was largely white and middle class. R55 ulitised a drop in centre and meals as a way of attracting clients to their office based services. R55, ASLP and CSC were each physically located within their target neighbourhoods but still reported a need

to provide outreach. R55 and ASLP both provided transport support to attend office based services.

In addition to outreach several programs provided outposted services into retirement villages, nursing homes and seniors centres. Group programs were often offered in diverse locations to create access for older people unable to travel long distances.

The two older person specific residential services, Hanley and GGFS, developed in response to a perceived need by people who felt that residential treatment is the most effective. Certainly there were wide spread calls amongst the other services for more older person specific residential services as older people do not do well in mixed age residential services. How older adult specific residential services differ will be discussed further below. Ms Colleran reported that the next step for Hanley is to develop a baby boomer specific service as the wants and needs of baby boomers differ from pre-baby boomers.

VISTA utilises a geriatric psychiatric unit for withdrawal as mixed age withdrawal units are viewed as not being suitable for older adults. COPA, OWL, ASLP, R55 and CSC all discussed a reluctance to refer to residential withdrawal as they believed their local services failed older adults.

In developing older person specific services the sector would develop staff with expertise in treating older adults. Clients, at the various services visited, reported that the staff providing the service seemed to have a greater understanding of the issues they faced in everyday life and were able to understand their cultural references and so on. Both clients and services reported the importance of

peer led approaches with Hanley, R55 and COPA involving sober older people in facilitating groups.

3. Raise awareness

All services reported that awareness of older adults AOD problems is poor across the spectrum, from health professional to family members to older adults themselves. COPA, OWL and Hanley each organise talks directly to groups of older people about AOD awareness. VISTA preferred to target health professionals or seniors identified as having issues. CSC and BCEVD deliver awareness sessions to culturally and linguistically diverse communities. R55, COPA and Hanley encouraged older people to raise awareness amongst their friends and communities and role model positive lifestyles. Since losing its treatment funding, SWAP is refocussing itself as an awareness raising organisation.

All services reported the importance of educating health profesionals to recognise the signs and symtoms of AOD use so as to avoid misdiagnosis.

The Florida BRITE Program seeks to assess all Florida residents over the age of 55 years for AOD issues and offer them an intervention to prevent the progression to serious AOD problems and their associated health concerns. In addition to providing services to individuals assessed, this program serves to raise awareness amongst health professionals of the need to assess for AOD use and address it.

4. Provide culturally and linguistically diverse services

Research has shown that as people age they retreat into their first languauge. As they become more socially isolated many older

people lose contact with the contemporary community. COPA, BCEVD, JMH, CSC and VISTA all provide services in languages other than English. For BCEVD and JMH, Spanish is almost as common as English amongst their clients. BCEVD pointed out that understanding the diversity of the Spanish speaking communities and their various cultural differences was as important as understanding Spanish itself.

5. Be convenient and useful

COPA, VISTA, BCEVD, CSC and R55 each described the importance of being able to provide crisis response and case management in parallel to AOD treatment. Older adults are more likely to maintain relationships with services who can work holisitically.

R55, ASLP and CSC are located in broader drop in services that provide medical services and social supports. St Mary's Center, where R55 is based, provides a meals service and crisis accomodation for older adults. CSC also reported the use of food to attract older adults to the centre. R55's allows for unscheduled counselling appointments as they state older adults can not always maintain set appoiintment times due to poor physical or mental health. All services spoke of the important role groups can play in reducing social isolation.

Several services gave examples of engaging older adults around improving health and quality of life as opposed to directly addressing addiction as this message was more palatable. One worker from VISTA said he introduces himself as '*being here to help you enhance your quality of life.*'

7. Be Accessible!

Two of the services visited featured large numbers of stairs which they both highlighted as limiting access to older people. Both services stated they would like to relocate or create access options, such as elevators, but were limited by funds.

6. Legislation

There were various pieces of legislation used by services to engage older adults in AOD treatment. Florida has the *Marchman Act* whereby families can petition the courts to commit loved ones into treatment. San Francisco has its own drug court that can enforce treatment. Canada can use its *Guardianship Acts* to enforce treatment and elder abuse laws to protect older people at risk of harm.

Legislation can also inhibit referrals. In Ontario, general practitioners are mandated to notify if they believe patients may be drink driving so they are disinclined to enquire about drinking habits to avoid the issue.

Treatment

What constitutes age appropriate and effective alcohol and drug treatment for older persons?
How does older person specific treatment differ from general adult drug treatment?

The services visited provided a range of AOD treatments including individual counselling and outreach, group programs and residential services. There was a general consensus that older adults do better and receive a better service from older adult specific treatment services. There was consensus that treatment approaches need to

be flexible, holistic and that outreach needs to be offered. Although treatment varied widely between the services there were some common themes about how older adult treatment is different to normal adult treatment:

- treatment requires longer episodes of care and needs to be slower, gentler, holistic and more flexible
- treatment is medically more complex
- loss, hopelessness and social isolation are more prevalent amongst older adults
- treatment is more likely to involve significant others
- treatment agencies are more likely to inadvertently create barriers to treatment
- non-medicated, or social, withdrawal is inappropriate.

Every service acknowledged that older adult AOD treatment is slower than general AOD treatment. Hanley and GGFS both explained that older adults require more breaks in residential treatment and the pace is slower than in a mixed age facility. Length of treatment varied amongst the outpatient services from six months to three years depending on the service. COPA reported a wide variation in treatment length of stay but in general reported that older adults require longer treatment engagement than younger people.

At OWL, the average treatment episode is around 3-6 months although many stay for more than a year, some up to two years. BCEVD reported the average length of stay at 12 months including after-care and, at VISTA, treatment engagement is open ended due to complexity of older adult AOD use. Two thirds of VISTA patients stay for two to three years. The Hanley Center operates on a 28 day model but GGFS has some clients stay for up to 18 months.

ASLP reported that sessions are generally shorter, 30-45 minutes, than in general AOD treatment and groups are kept smaller so as to not overwhelm participants. R55 stated services need to be flexible especially around missed appointments as older adults can often miss appointments due to poor health. Despite this, OWL has higher attendance levels than the City of Hamilton's generalist treatment programs and OWL clients are more likely to advise when unable to attend.

Several services described how older adults' cognitive functioning may take weeks to recover after withdrawal. Hanley reported that it is normal for older adults to perform poorly in mental state exams when first entering treatment. Following withdrawal older adults can slowly recover capacity. Younger people regularly respond quickly but older people may take several weeks. Hanley reported examples of older people entering its facility in wheelchairs with diagnoses of dementia and at 28 days being able to walk out of service with normal cognitive functioning. VISTA, GGFS and R55 reported similar examples. GGFS stated it sometimes takes their residents 30 days before they achieve a good night's sleep.

COPA believe flexibility and a preparedness to work with where the client is is central to older adult AOD work. COPA see the strengths of their approach in their ability to provide outreach, concentrate on the client/worker relationship and their capacity to provide longer treatments. COPA reports that the stigma associated with having AOD issues can slow down treatment as it can take a long time to address stigma.

Hanley stated that the client/worker relationship is integral to change with older adults so treatment needs to focus on building the relationship and developing trust.

Many older adults initially contacted services when they were in crisis. Crises may be related to health, housing or financial issues. Older adults may be being abused. Assisting with crisis can be a way of developing the client/worker relationship and create opportunities to address AOD issues. Providing holistic services that address these needs takes longer.

All services reported that older adults have more complicating medical issues and are likely to be on a wider variety of medications. COPA reported that their clients are on an average of 4-12 medications each, complicating treatment and making adequate medical support throughout treatment a necessity. Medication mismanagement is an issue regularly confronted by treatment services. Workers need to have an understanding of the effects of ageing on the body. Improved health was reported as a key motivator for older adults.

Older adults experience more transitions than other adult clients. Older adults face loss of employment, loss of mobility, loss of health, loss of peers, loss of partner, loss of hope and loss of identity. Many older adults find it hard to imagine a positive future. Many older adults feel unneeded and useless. With shrinking incomes they may have difficulty maintaining or establishing social networks. AOD treatment focuses on shifting motivation and creating change for a better future. Many older adults believe their life is coming to an end. The Hanley Center undertakes a spiritual assessment with all new residents. At Hanley, spirituality is about moving from doing to being; moving from the material to the spiritual. Spirituality is about learning to be comfortable with *who you are* rather than *what you do*. Spirituality assists older adults

cope with their perceived loss of identity due to the many transitions in their life.

BCEVD and VISTA agreed older adult AOD treatment requires a greater emphasis on spirituality and both services see addressing spiritual needs as core AOD work with older adults.

Nicole Johnson, at GGFS, explained that many of the clients her program sees have long histories of criminality and violence. In some cases 30-40 years. For these clients, once drug free, looking back on their lives can be as confronting as looking forward. Ms Johnson said that a great deal of time in treatment can be spent with clients re-establishing value systems and coming to terms with the past. Ms Johnson stated older adults can become overwhelmed and unable to express their sense of anguish and grief at their past deeds. She said that she has found journaling to be a useful tool with older adults.

COPA stated that older people are motivated in treatment by reconnection with loved ones, improvements in their quality life, making friends and the opportunity to put structure and meaning back into life. Opportunity to improve one's health was sited by most services as a key motivator for older adults. VISTA, BCEVD, CFDFL and COPA each market their group programs as being about healthy lifestyles. Peer led approaches were acknowledged as particularly useful in creating hope for older adults, especially as AOD workers were rarely as old as their clients.

Many older adults are motivated to attend AOD treatment by the desire to re-establish relationships with loved ones. COPA, VISTA, Hanley and ASLP all reported higher levels of worker engagement of significant others than one would expect in a general AOD service.

Services assisted in mediating relationships with estranged loved ones and children.

There a number of ways that AOD agencies inadvertently create barriers to treatment for older people. Service criteria that exclude on the basis of mobility, English competency, general health, cognitive capacity, hearing, literacy, motivation or ability to pay, all discriminate against older adults. Residential services that exclude on the basis of health concerns directly discriminate against older adults.

R55 stated that the only medical withdrawal service available to their clients excluded people over the age of 62 due to health risks and that local hospitals would not admit for withdrawal except in cases of medical emergency. Several agencies suggested that smokefree policies discourage older adults from attending treatment facilities as many older adults have been smoking for 50-60 years and have failed numerous cessation attempts. Services endeavoured not to operate wait lists, where possible, as it was felt that this discouraged older people from attending treatment.

Non-medical withdrawal was not deemed suitable for older adults and in jurisdictions where that is the only option, such as Ontario, services prefer to support clients through slow non-medicated reductions. OWL stated that non-medicated withdrawal is not appropriate for older adults as they are more likely to suffer seizures. Hanley and VISTA, who both provide medicated withdrawal options, said older adults require longer and slower withdrawals than younger people.

Both Canada and the United States of America have produced older adult treatment guidelines that summarised the general approaches used in each country:

- Health Canada, *Best Practices - Treatment and Rehabilitation for Seniors with Substance Use Problems* (2002), http://www.hc-sc.gc.ca/hl-vs/pubs/adp-apd/treat_senior-trait_ainee/
- U.S. Department of Health and Human Services, SAMHSA, Substance Abuse Among Older Adults (1998), http://ncadistore.samhsa.gov/catalog/productDetails.aspx?ProductID=13287

Contributing factors

What factors assist older persons to change their drug using behaviours?
What impedes treatment effectiveness?
What complimentary services support this?

There are a range of factors that can have positive or negative impact on the success of a client's AOD treatment. Many of these can be easily managed by agencies and some can seem insurmountable. Lynn Guelzow, Director of Prevention Programs at Hanley, suggested that professionals may need to start recognising and acknowledging that older adults, like adolescents, have specific risk and protective factors which determine the likelihood that they will develop mental health or AOD issues.

Cultural and linguistic diversity

Older adults especially like to receive services in their first language. COPA reported that many older adults will move back into

their first language despite having spoken English when they were younger. For this reason COPA provides services in two other languages other than English. CSC and BCEVD both expressed that language should not be confused with culture. BCEVD explained that they service many different Spanish speaking communities that reside in their catchment and one should not assume, for example, that Cubans and El Savadorians culturally the homogenous just because they speak Spanish. Similarly CSC explained that the various Asian communities in San Francisco are culturally quite independent of each other.

The gay and lesbian community was also identified as a community that requires consideration when considering cultural diversity.

Health and mental health

Every service highlighted older people's health as having a significant impact on the capacity for recovery. Both physical health issues and mental health issues were identified, particularly high prevalence disorders such as anxiety and depression. COPA estimates that 80-90 per cent of their clients would be suffering high prevalence mental health disorders such as anxiety or depression. R55 put the figure at 75 per cent. COPA report a high number suffering other complicating conditions such as dementia.

Fear was raised as a significant issue and was particulalry significant for those programs that serviced marginalised communities or those services that were physically based in unsafe neighbourhoods. With increasing numbers of veterans attending services, issues related to war and trauma are common. Some services, VISTA, CSC, R55, JMH and Hanley, were fortunate to have medical professionals on staff or to be co-located with medical clinics. Other services found

managing health issues more difficult, particularly as North America does not provide universal health cover. Programs often assist in referral to home help services where these are provided. R55 reported that older adults attend their service who have not had a doctors appointment in 20 years.

Poverty

Poverty was continually raised in relation to clients' ability to maintain housing, get medical attention, feed themselves and participate in community life. Workers are constantly confronted with clients inability to survive from week to week. This makes encouraging participation in social activities particularly difficult. Again, this is a particular difficulty of the American system where a government pension is not guaranteed to cover the cost of public housing. Many of the services, particularly those based in larger welfare services such as R55, ASLP and CSC, offered a range of services to assist in the alleviation of poverty such as free meals, transport assistance, free social activities and free medical care.

Shame

Several programs related the great shame felt by older adults when admitting to AOD issues or having to ask for help. Many older adults requiring services had lead full lives and had no history with support services prior to falling into crisis at an older age, perhaps related to suddenly becoming unemployed or getting evicted. JMH and R55 both reinforced the need for unconditional positive regard when working with older adults. Nico, from BCEVD, said he always lets older adults know that he feels privileged to be able to spend time with them and gain from their wisdom.

Social isolation

Possibly the most significant contributing factor across all spectrums of older adults experiencing AOD problems is social isolation. The older adults, attending the programs visited, tended to have decreasing circles of friends and family. They were mostly retired or unemployed. Many were widowed. Many had become isolated due to health concerns or worsening mental health. Many could not afford to pay for transport or activities. Many had little or no family or had burnt those bridges. COPA suggested that in Canada, many older adults are forced to return to urban environments as this is where necessary health services are located thus, leaving their established communities behind.

Programs had differing ways of dealing with isolation. The two residential services, Hanley and GG4S, did not provide single rooms. Dan Hogue, from Hanley, explained:

> *'Addiction is a disease of isolation so shared rooms ensure people are not able to further isolate themselves in treatment.'*

Hanley encouraged participation in 12-step meetings following discharge, to encourage fellowship and decrease the pressures of isolation. Hanley also organised alumni meetings where ex-clients can come together for mutual support.

COPA, Hanley, R55, ASLP and and SWAP provided volunteering opportunities within their own agencies to decrease isolation. COPA have established the COPA friend program that is a volunteer program that provides a range of opportunities for older people to volunteer their time. COPA friends provide clients with social supports and transport/escorting. COPA friends assist with running

morning teas and other social functions such as the annual fundraiser 'COPAcabana'.

R55 provided opportunities for older people to volunteer as sobriety leaders running groups, as seniors companions or within the childcare and kindergarten services. R55 provided training for older adults to be become public policy advocates. R55 trained on public speaking, formulating submissions and organising rallies. R55 clients had assisted in the building of a giant paper mache Martin Luther King Jnr, that stood watch over the drop-in-centre and regularly attended public rallies.

COPA works extensively in assisted living centres and recognised that older adults have often lost the social skills required to fully participate in community life. COPA developed the COPA college to try to address this. COPA college provides life skills training for older people and is offered in assisted living centres. It particularly targets those older adults at risk of being evicted due to their behaviours. The training includes communication skills, stress management and relationship skills.

CFDFL and BCEVD encouraged older adults to participate more fully in family life, particulalry with grand children. All services endeavoured to refer into established community support programs. ASLP, BCEVD, R55 and CFDFL were located in larger agencies that provided broader engagement services such as community kitchens and organised social groups.

ASLP reported that they often meet male clients who have become widowed and have little idea how to cook or clean for themselves. Abbottsford Community services in which ASLP is based has programs which seek to address this.

Abuse

Older adults can be targets of abuse which compounds health issues and in turn impacts on AOD use. Canadian services were particularly conscious of this and were able to cite existing legislation in place to address this. VISTA explained there is a rise in the pension from $700 to $1,100 at 65 years of age. Vulnerable adults can become targets of younger family members, or even strangers, who are aware that there will be a pension increase.

Workforce

What skills and knowledge do treatment staff require to effectively engage and treat older persons problematic substance use?

Literature suggests that staff should be specifically trained to provide AOD treatment with older adults. The services visited varied in their responses when questioned about what they look for when employing new staff. There was a general feeling that staff in mixed age services are often frustrated by older adults as the treatment is slow, health issues can be complex and older adults are motivated by very different things to younger people.

All the services suggested that staff who solely provide older adult treatment become more resilient. They learn to find success in incremental change and learn to enjoy and value older adults. Services stated that it is important for programs to assist staff with recognising that older adult treatment has a different measuring stick for success and workers need to be supported to find positive outcomes in order to motivate themselves.

The common skills and qualities most regularly suggested as necessary were:

- knowledge of, or background in, gerontology particularly in relation to medications used by older adults
- qualifications in AOD treatment
- respect for older adults and their place in the community
- patience and perseverance
- strong boundaries.

COPA employs a range of staff from diverse backgrounds. When recruiting staff, Robert Eves stated, he seeks to employ workers who can be 'jacks of all trades'. Workers need to be able work through issues slowly and not become overwhelmed by the full picture. Workers are often the only person in the older persons' life and are faced with clients who see the worker as a friend. Workers can be asked to assist with decisions around property or finances. Staff are often faced with issues that have no apparent solution. COPA utilises team case consultations as a means of supporting case workers.

All staff within Hamilton City's Alcohol Drug and Gambling Services are social work trained. The **OWL** program recruits staff with a background in gerontology. Staff working with older adults need a good knowledge of medications and their interactions due to the number and range of medications used. Workers need a good understanding of older person's health issues including cognitive changes brought on by ageing. Staff need experience in grief and loss work and an understanding of how fear impacts upon older people particularly those with no family support.

CFDFL looks for staff who are people oriented and able to engage older people. Staff need a good knowledge of gerontology and

medications. Staff need to be compassionate, patient and exhibit a sensitivity for seniors. CFDFL looks favourably on staff who are bilingual. Staff need good presentation skills as CFDFL regularly calls upon staff to engage in public speaking. Younger staff need good boundaries as clients can often want a parental type relationship.

BCEVD employs certified addiction specialists and trains them to work with older persons. All staff have bachelor level qualifications and are supported to advance to masters level. Staff need to be sensitive, empowering and able to engage older people. BCEVD serves a large Spanish speaking population so an ability to speak the language is an asset.

VISTA employs staff under a range of qualifications; social work, nursing, psychologists and occupational therapists. VISTA looks for staff with a background in gerontology more so than addiction. VISTA seeks team players as much of the work is unsupervised and staff who isolate themselves or don't know when to ask for help struggle. For this reason new graduates do less well.

VISTA utilises a goal attainment scale in evaluating client progress to assist staff to recognise and acknowledge that staff effort is having an effect. VISTA assesses potential employees for suitability for outreach work, that is, staff with strong risk evaluation skills.

CSC employs staff who have experience in outreach service provision and risk management. CSC looks for staff with experience in AOD treatment and/or gerontology. CSC believes it is important to find staff who are able to self manage, listen and take direction.

R55 stated it is important that staff be trained to assess for high prevalence mental health issues such as anxiety and depression as these are common amongst older people. R55 also raised that it important that medical practitioners have experience or training in treating older adults, particularly, in relation to medication dosing as there is often a tendency by inexperienced practitioners to dose at normal adult rates.

4. Improving the Victorian healthcare system

I have learnt a great deal about what constitutes quality AOD treatment for older adults and what barriers older adults face in accessing treatment. I have become an advocate for older person specific AOD treatment.

Even prior to departing for North America, the Victorian Travelling Fellowship was having an impact on Peninsula Health. The fellowship sparked discussions between the AOD service, aged psychiatry and aged care.

Following the travel component of the fellowship, these three areas of Peninsula Health will be undertaking regular meetings to develop initiatives to address older adults AOD issues locally. The fellowship has raised awareness amongst AOD staff of the needs of older adults and had created discussion and excitement about the possibility of providing targeted services in the future.

Peninsula Health is committed to piloting an older adult AOD project in 2008-09 and to developing projects that address the AOD and broader needs of older adults.

Peninsula Health will establish a network of interested parties locally that will support the development of local initiatives to address problematic AOD use amongst older adults. Platforms, such as primary care partnerships and the Mental Health Alliance, will be able to provide support and opportunities to raise awareness amongst key agencies and service providers.

This investigation has been about an area of treatment that doesn't currently exist in Victoria. Any improvements in the broader service sector, such as the development of older adult specific service provision, would require the commitment of funds by the state and/or federal governments. The preference would be to pilot an older person specific treatment option with a view to broader funding if the pilot succeeds in creating access for older people into AOD treatment and decreasing AOD related harm. At a minimum, clinical treatment guidelines need to be developed that support agencies to create access and effectively treat older persons AOD issues.

Although still in its infancy, the Florida BRITE project is reportedly showing good results in reducing AOD related harm, limiting progression from concerning AOD use through to addiction and reducing AOD related hospital admissions amongst older adults. In Victoria, the Hospital Admission Risk Program and the Early Invention in Chronic Disease initiative undertake similar initiatives in relation to other areas of chronic disease. VISTA, JMH and BRITE all gave strong economic arguments for funding older adult early intervention and treatment when examining a global health budget. An early intervention program, like BRITE, could be an opportunity for the AOD sector to look beyond its traditional boundaries and partner with broader health agencies.

Depending on what types of services develop, monitoring improvement outcomes could include:

- monitoring numbers of older adults accessing treatment
- monitoring agencies that have developed older person engagement plans
- monitoring numbers of workers that undertake training in the provision of treatment to older adults
- monitoring reduction in hospital admissions amongst older adults admitted for substance related issues
- monitoring the number of agencies that involve older adults in consumer engagement activities
- monitoring the number of health promotion activities undertaken that target older adults substance use.

Both the Victorian Alcohol and Drug Association (VAADA) and the Council On The Ageing Victoria (COTA) have expressed interest in the outcomes of the fellowship. Both VAADA and COTA would be prepared to support the development of older person specific responses through participation in steering groups and promotion through their memberships.

5. Sharing and promoting the project

Presenting findings at conferences:

- Abstract accepted for *'Substance Use across the Lifespan'* conference 25-26 July 2008.
- Abstract submitted to Australasian Professional Society on Alcohol and other Drugs (APSAD) Annual Conference in Sydney, 23-26 November 2008 (awaiting outcome).
- Request from the Victorian Alcohol and Drug Association (VAADA) to present at their conference in February 2009.

Both Turning Point Alcohol and Drug Centre Inc and VAADA have offered to facilitate information sharing sessions.

Jenny Tinworth, Managing Editor, *Of Substance – The National Magazine on Alcohol, Tobacco and Other Drugs*, has expressed an interest in the outcomes of the fellowship and has requested an abstract to present to her editorial reference group.

Meetings, to inform of the findings, will be held with:

- Department of Human Services Mental Health Division
- Department of Health and Ageing
- Sue Hendy, Executive Director, COTA
- the VAADA Board
- the Southern Metropolitan Region AOD Managers' Network
- the Peninsula Health Department Heads.

Copies of the fellowship report will be distributed to relevant State and Federal ministers.

Copies of the findings will be distributed to each of the agencies visited during the travel component of the fellowship. Many of the agencies expressed a desire to learn what each other was doing.

Other opportunities will be taken as they arise to disseminate the findings of the fellowship.