# ADDICTION SERVICES FOR OLDER ADULTS

# ADDICTION SERVICES FOR OLDER ADULTS: A SERVICE PROVIDER PERSPECTIVE

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A Thesis Submitted to the School of Graduate Studies in Partial Fulfilment of the Requirements for the Degree Master of Arts

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# ABSTRACT

Substance abuse is a major public health concern. Scholars predict a growing proportion of people aged 50 years and older suffering from addiction to alcohol, prescription or over-the-counter medications and/or illegal substances (Wu & Blazer, 2011; Han et al., 2009). Available Canadian statistics reveal that 6-10% of older adults experience alcohol problems, 1% use illegal substances and approximately 6% seek addiction treatment for prescription opioids (Public Health Agency of Canada, 2010; Tjepkema, 2004; CAMH, 2008). Older adults face personal, social, and structural barriers to treatment, which result in a significant number of people living with addiction and remaining undiagnosed and untreated in the community (Crome & Bloor, 2005b). Nevertheless, this issue is significantly understudied and under-recognized, particularly within Canadian literature.

This qualitative research study examined the perspectives of addiction service providers regarding the issue of addiction among older adults. A descriptive, qualitative research design was used to explore the perspectives of addiction service providers using in-depth, semi-structured personal interviews. Purposive sampling techniques were used to recruit 24 service providers employed by Hamilton addiction services. Semi-structured interviews included questions on (a) the current provision of addiction services for older adults, (b) characteristics of older adults (c) perceived barriers to treatment, and (d) recommendations for addressing the needs of older adults living with addiction. The interview also collected demographic information to describe the demographic profile of agencies and research participants involved in the study.

By using Braun and Clarke's (2006) phases of thematic analysis, this study observed several key themes that confirmed and extended existing literature. New contributions highlight the following: (1) according to service providers, older adults demonstrate a greater readiness for change and stronger commitment to their treatment plan regardless of whether they are enrolled in a mixed-age or age-specific program. (2) Some older adults use substances to cope with cumulative shame that stems from unresolved, traumatic early-life experiences. This new finding supports principles of the life course perspective by highlighting the impact of early life events on late life experiences. (3) Service providers can address some of the age-specific needs of older adults by assigning them to an older counselor in treatment. (4) In order to enhance treatment outcomes, older adults should *direct* their care and be viewed as experts in their treatment needs. (5) From the perspective of service providers, older and younger adults benefit from interactions with each other when the older adult is in recovery and the younger adult is recovering. Older adults recovering also benefit from interactions with older peers in recovery, particularly when they are in mixed-age programs. Opportunities for peer interaction during and after treatment can produce favourable recovery outcomes.

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# LIST OF ABBREVIATIONS

| | |
|---|---|
| AA | Alcoholics Anonymous |
| ADE | Adverse Drug Event |
| CAMH | Centre for Addiction and Mental Health |
| CAS | Canadian Addiction Survey |
| CCSA | Canadian Centre on Substance Abuse |
| COAST | Crisis Outreach and Support Team |
| CSI | Consumer Survivor Initiatives |
| CWMS | Community Withdrawal Management Service |
| DART | Drug and Alcohol Registry of Treatment |
| DAWN | Drug Abuse Warning Network |
| DSM-IV-TR | Diagnostic and Statistical Manual of Mental Disorders - 4$^{th}$ Edition (Text Revision) |
| ED | Emergency Department |
| HNHB | Hamilton, Niagara, Haldimand, Brant |
| LHIN | Local Health Integration Networks |
| LTC | Long Term Care |
| MoHLTC | Ministry of Health and Long Term Care |
| MI | Motivational Interviewing |
| OTC | Over-the-Counter |
| PSSS | Partners Seeking Solutions with Seniors |
| SAMHSA | Substance Abuse and Mental Health Services Administration |
| WHO | World Health Organization |

# INTRODUCTION

According to Carol Beynon and colleagues (2011), we have entered the age of the aging. Worldwide trends of declining fertility and increasing life expectancies suggest that this demographic transition will become more pronounced in the years to follow. In Canada, recent population projections suggest that by 2036, individuals aged 65 years and older will comprise approximately 25% of Canada's total population (Statistics Canada, 2010a).[1]

As Canada's population ages, contemporary scholars predict that a growing number of older adults will misuse and become addicted to prescription and over-the-counter (OTC) medications as well as alcohol and illegal substances. Canadian statistics on substance use reveal that approximately 6 to 10% of older adults (aged 65 and older) live with alcohol problems and 1% of adults aged 55 years and older use illegal substances (Public Health Agency of Canada, 2010; Tjepkema, 2004). Moreover, Gfroerer, Penne, Pemberton and Folsom (2003) estimate that the number of older adults requiring substance use treatment will double by 2020. Research findings cite the availability, frequency and "social acceptance" of licit and illicit drug and alcohol use in the 1960's as one of the primary reasons for an increase in substance abuse in midlife due to the aging of the baby boom cohort (Wu & Blazer, 2011). The established connection between an increased risk of use in later life and heightened exposure to substances during early adulthood suggests that baby boomers will be more likely to struggle with

[1] In addition, the female proportion of older adults will continue to exceed males. In 2010, women accounted for 55.6 % of individuals aged 65 years and older, 63 % for those aged

addiction issues as they age (Wu & Blazer, 2011; Han, Gfroerer, Colliver & Penne, 2009; Sorocco & Ferrell, 2006; Gfroerer et al., 2003). [2]

As a major public health concern, increased use of psychoactive substances among older adults will lead to negative health and social consequences. In fact, it is widely recognized that prolonged substance use, whether alcohol or drug-related, can have detrimental effects on an individual's health and wellbeing by not only reducing the number of disability-free years, but also by robbing individuals of their projected life expectancies (Crome, Sidhu & Crome, 2009; Cummings, Bride, McClure & Rawlins-Shaw, 2008).

Interestingly, older adults are particularly vulnerable to the deleterious effects of substance abuse (Cummings et al., 2008). Dr. Stephen Bartels and colleagues (2005) attribute age-specific vulnerabilities as related to the psychological, biological and social changes that accompany the aging process, such as poor physical health, diminished social networks, and increased feelings of loneliness, stress and anxiety (Centre for Addiction and Mental Health [CAMH], 2008b).

While older adults with an addiction experience reduced health and wellbeing, current statistics of drug and alcohol use in Ontario reveal that just 7.1 % of all those in

[2] Gfroerer et al. (2003) describe findings from a SAMHSA study that supported higher rates of alcohol and illicit drug use among older individuals who belonged to birth cohorts, such as the baby boomers, that experienced high rates of substance use during their youth. In addition to being more likely to use alcohol and illicit drugs than previous and subsequent generations, the baby boom cohort is also known to be larger than preceding cohorts (Gfroerer et al., 2003). Taken together, it is likely that the prevalence of substance use among older adults will increase as the baby boom generation ages; therefore pointing towards the need for a systematic approach to addressing this issue in the coming years (Wu & Blazer, 2011; Han et al., 2009; Sorocco & Ferrell, 2006; Gfroerer et al., 2003; Blow et al., 2000).

addiction treatment are above the age of 55 (CAMH, 2008). Of these individuals, reported problems include an addiction to alcohol (84.7%), prescription opioids (5.7%), cannabis (5.3%), crack cocaine (4.6%) and intravenous drug use (6.9%). While substance abuse is more common among younger adults, the current proportion of older adults enrolled in addiction treatment programs suggests that a significant number of older adults either remain untreated and hidden in the community or have access to healthcare services that fail to identify or neglect substance use concerns. For this reason, scholars in the field of addiction and aging define problematic substance use in late life as a "silent epidemic" (Crome & Bloor, 2005b). In fact, many older adults struggle with personal, social and systematic barriers that restrict access to appropriate treatment centres. Barriers include: a lack of age-specific services, neglected mental and physical health problems, denial, social stigma and discrimination, enabling attitudes and behaviours, misdiagnosis, under-diagnosis, and a lack of training and ageist attitudes among some healthcare professionals (CAMH, 2008; Health Canada, 2002; Coogle, Osgood & Parham, 2000).

A few studies have explored preventable and unnecessary healthcare service use among older adults and have concluded that substance abuse among this population is associated with an increased use of resources, including visits to emergency departments (ED), hospital admissions, physician visits, medication use, and diagnostic tests (Sikdar et al., 2010; Onen, Onen, Mangeon, Abidi, Courpron & Schmidt, 2005; Flemming, Manwell, Barry, Adams & Stauffacher, 1999). For example, Wu and Blazer (2011) reported findings from a United States (U.S.) Drug Abuse Warning Network (DAWN) study, which revealed that more than half a million visits to the ED involved nonmedical

use of pharmaceuticals. Among individuals aged 55 and older, opioids and benzodiazepines were identified as the two most cited reasons for medication visits to the ED; and most visits were associated with the use of other substances, mainly alcohol, which was present in 65% of visits for opioids and 76% for benzodiazepines. With the recent focus on reducing avoidable ED costs in Ontario, it is imperative that scholars work with service providers to identify the needs of older adults and improve the readiness of services to address their unique needs (Hamilton, Niagara, Haldimand, Brant Local Health Integration Network [HNHB LHIN], 2009).

Ultimately, preventable use of healthcare resources can lead to significant healthcare costs. In 2002, Health Canada identified substance use as a powerful contributor to rising healthcare expenditures (Wu & Blazer, 2011). A study conducted by Rush and Ogborne in 1992 estimated that approximately $300 million per year was spent on substance abuse treatment (as cited in Health Canada, 2002). By 2002, research findings from the Canadian Centre on Substance Abuse ([CCSA]; 2006) revealed that the estimated overall social cost[3] of substance abuse was $39.8 billion. In the absence of more recent statistics, it is reasonable to assume that these costs have since increased.[4]

[3] CCSA defines "social" costs as the burden on services such as law enforcement and health care, the loss of productivity at home or in the workplace resulting from disability or premature death due to substance use (CCSA, 2006).
[4] Sikdar and colleagues (2010) conducted a study of 1,458 patients who presented at two EDs in Newfoundland and Labrador; 55 individuals were identified as visiting the ED due to experiencing an adverse drug event (ADE). The study found that prevalence of an ADE increased with age (0.7% for individuals aged 18-44; 1.9% for 45-64 years, and 7.8% for individuals 65 years and older) and that the average age of patients with an ADE was higher than those without an ADE, ultimately, illustrating the relationship between increased age and use of healthcare services.

**Gaps in the Literature**

The current research study aims to respond to many of the issues described above by drawing attention to the issue of older adults with substance use concerns and encouraging the age-specific planning of existing programs and new initiatives. This study aims to address several gaps in existing literature. First, substance abuse among older adults is a significant yet understudied and under-recognized issue. After conducting an extensive literature search, only 5 research articles were retrieved that focused on older adults with addiction from the perspective of service providers (Health Canada, 2002; Partners Seeking Solutions with Seniors [PSSS], 2004; Schonfeld, Rohrer, Zima & Spiegel, 1994; Brown, 1984; Andrews, 2008). Second, of these articles, the most recent study was conducted in 2008 by Christina Andrews and it not only focused specifically on older adults of Latino descent but it was also based in the U.S.

Third, only 2 studies were conducted in Canada and are fairly dated. The most recent Canadian study was conducted nearly a decade ago in 2004 by a group of stakeholders known as Partners Seeking Solutions with Seniors (PSSS) and is preceded by a research study conducted by Health Canada in 2002. Fourth, there is a gap in existing literature on research methods that collect data via face-to-face interviews. The PSSS (2004) study gathered data through 62 surveys (which was a low response rate of 15.5% out of 400 surveys) and a held forum in 2003 that gathered data through focus groups with approximately 80 people in attendance. Moreover, the Health Canada (2002)

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In addition, a study conducted in the United Kingdom by Dent, Hunter and Webster (2010) reported that a majority of people who frequented the ED had a history of problematic alcohol or illegal drug use (54.6 and 15.9 %, respectively), and the average age of frequent ED attenders[4] was 49 years of age (ranging from 19 to 83 years).

study collected data by telephone or email interviews with 29 key experts across Canada. While both studies are comprehensive and present relevant findings to the field, they are limited by the fact that interviews were not conducted in person. There is research that recognizes the benefits of personal interviews as an effective research method for collecting rich data, having a high response rate, allowing flexibility in interview questions, including complex and more involved questions in the interview guide and providing the opportunity to observe verbal and non-verbal behaviours of study participants (Neutens & Rubinson, 2002). Fifth, none of the Canadian studies were geared specifically to the needs of seniors living in Hamilton, Ontario even though Ontario has the 3$^{rd}$ and 4$^{th}$ highest life expectancy for men and women, respectively, and the age profile of Hamilton demonstrates seniors are slightly older than seniors living in Ontario (Statistics Canada, 2008; Mayo, Wetselaar, Bakht & Camplin, 2011). These gaps signify a need to conduct more research that is based in Canada, focuses on the general population of older adults, and collects data via personal interviews in order to capture the current state of addiction services for older adults as well as the barriers to treatment and current living conditions/characteristics of older adults living with an addiction.

Using Hamilton as a case study, this exploratory study aims to build on existing literature and lay the groundwork for future research by (a) examining the perspectives of service providers (managers and front-line workers) regarding the issue of addiction among older adults; (b) identifying solutions and recommendations for improving access to treatment and supporting the needs of older adults in treatment programs; and (c) increasing awareness of this issue among service providers and encouraging planning

groups to strategize for the growing number of older adults who will be accessing addiction services in the future.

This study will examine the perspectives of addiction service providers since they are an integral component of the healthcare delivery system. Service providers not only provide direct clinical care but also are involved in the process of identifying current needs and future challenges, advocating for the rights of consumers and participating in collaborative planning committees to capitalize on opportunities for improving the quality, quantity, accessibility and flexibility of treatment services for people with lived experience of addiction (Department of Mental Health and Addiction Services, 2002). For this reason, it is important to study the perceptions of service providers as experts who are uniquely knowledgeable on the recovery needs of clients.

Thus, the present research study will explore four general research questions from the perspective of service providers, including: 1) what addiction services are currently being provided for older adults with substance use concerns? 2) What are the unique treatment needs of older adults with substance use concerns? 3) What are the current barriers faced by older adults to access addiction services? 4) What are service providers' recommendations for improving the current addiction system to meet the needs of older adults?

The following section will provide a review of existing literature on older adults with substance use concerns. It will begin by briefly defining relevant concepts to this research project and reviewing the literature on substance abuse in an aging population. The review will include an analysis of patterns of alcohol, illicit and licit substance use

among older adults, including an exploration of consumption patterns and prevalence rates. It will also provide literature on the treatment of substance use problems, which will include an explanation of the concept of "age-specific" interventions and tailored treatment, a description of treatment settings and existing barriers to treatment.

# REVIEW OF THE LITERATURE

## Methodology of Literature Review

The following literature review was conducted during the spring and summer of 2011 and was updated in the fall of 2012. In order to capture relevant literature on the prevalence of substance abuse, the characteristics of older adults and barriers to addiction treatment, a number of databases were used to access peer reviewed journal articles from the interdisciplinary research fields of substance abuse and aging. Relevant databases included OVID, Medline, Ageline, PsychINFO and Google Scholar. OVID, Medline, PsychINFO and Ageline were used to gather information on the patterns of consumption and prevalence of alcohol, illicit and licit drug use. In addition, Google Scholar helped capture government publications from Health Canada, Statistics Canada and other reputable research centres such as the Centre for Addiction and Mental Health (CAMH), the Canadian Centre on Substance Abuse (CCSA) and the Substance Abuse and Mental Health Services Administration (SAMHSA). Several key words were used to identify relevant information for this research study. Key words included: aging, aged, older adults, age-specific care, substance related disorders, substance abuse/use/addiction/ dependence, assessment, psychosocial interventions and treatment outcomes.

Research articles obtained from databases were reviewed using the following inclusion criteria: (a) articles that targeted older adults with addiction concerns, and (b) research on the prevalence of addiction that was based in Canada. Due to the prediction that few articles would meet inclusion criteria, when needed, research regarding barriers and treatment approaches were gathered from sources outside of Canada. Moreover,

publications from 2000 to 2012 were reviewed with the exception of a few pertinent research studies from the 1980s and 1990s. Special attention was given to research from 2008 to present; however, gaps in recent literature made it necessary to reference research findings from earlier studies.

**Terminology**

A review of the literature reveals that there are a number of pervasive terms in the field of addiction and aging that are relevant to older adults with substance use concerns. To begin with, it is important to clarify the term "older adult," since there is variation in what researchers in the field of addiction and aging define as "senior" or "older adult." In order to be inclusive of relevant research in the area of substance use among older adults, the following literature review will examine research studies on older adults with cut off ages ranging from 50 and older. The following section will define substance abuse and early-onset versus late-onset substance use.[5]

**Substance abuse.** A variety of terms pertaining to substance abuse have been found within existing literature. CAMH (2008a) and the World Health Organization ([WHO]; 2011) define substance abuse as the continuous consumption of a substance regardless of its negative impact on a person's social, occupational, psychological or physical wellbeing. Relevant substances include licit prescriptions and OTC medications, as well as alcohol and illegal drugs such as marijuana, cocaine and heroin.

There is a distinction between use, misuse and abuse of substances that is briefly worth noting. Use refers to the act of using or consuming a substance, such as the act of

[5] Other relevant terms, including: substance dependence, addiction and young-old versus old-old can be found in Appendix A.

consuming alcohol. The term misuse insinuates the use of a substance at a higher rate than prescribed or directed, such as neglecting physician instructions by consuming higher doses of prescribed medication. Misuse becomes abuse when the act of consuming a substance negatively impacts a person's health and wellbeing, such as the negative impact of heroin abuse on maintaining a secure occupation.

**Early-onset versus late-onset substance abuse.** A significant body of literature exists on the age of onset of problematic substance use in older adults. Generally speaking, scholars have divided older adults with lived experience of substance abuse into one of two categories, known as early-onset or late-onset substance abuse (Clay, 2010; Cummings et al., 2008; Hanson & Gutheil, 2004; Fingerhood, 2000). Individuals with a long history of substance abuse fall into the category of early-onset. According to Hanson and Gutheil (2004), the early-onset group includes people who develop substance abuse problems prior to reaching 60 years of age and these individuals account for two-thirds of all older adults who abuse substances (Clay, 2010; Fingerhood, 2000). These individuals also tend to have smaller social networks, legal or financial problems, a history of receiving treatment from substance abuse programs and are more likely to drink to intoxication (Flood & Buckwalter, 2009).

Individuals who develop substance abuse problems after the age of 60 fall into the late-onset group of people with lived experience of substance abuse. Hanson and Gutheil (2004) describe the actions of these individuals as "reactive" to the social, physical and psychological changes that accompany the aging process. These individuals, which are more likely to be female, tend to have stronger societal connections (i.e. involved in a

marital relationship and no prior experience of being in a correctional facility) and have a better recovery prognosis, since they did not endure the psychological and physical struggles of those with lived experience of long-term substance use problems (Coulton, 2009; Benshoff & Harrawood, 2003).

**Substance Abuse in an Aging Population**

**The aging process and misdiagnosis of substance abuse.** Scholars describe the aging process as a combination of physical, psychological and social changes. It is important to recognize that certain physical and physiological changes occur with age that may be caused by or exasperated by substance abuse (Scott, 2008). Changes include a loss of density in bones and joints, hearing and vision loss, the replacement of lean body mass with body fat, as well as hormonal, gastrointestinal changes and high blood pressure (CAMH, 2008; Health Canada, 2002). Physical problems that result from prolonged and/or heavy use of substances include injury from falls, liver disease, gastrointestinal disorders, heart problems, cancer, nutritional deficiencies, sexual dysfunction and potentially life-threatening withdrawal complications (Lin et al., 2011; Clay, 2010; Flood & Buckwalter, 2009; CAMH, 2008; Health Canada, 2007; Crome & Bloor 2005b; Health Canada, 2002; Blow, 1998).

Cognitive changes can also occur with increased age, and may be a consequence or contributing factor of addiction. Experiences of dementia, depression[6], sleep disorders and anxiety as well as perceptions of powerlessness over the aging process ultimately

[6] A review of the literature suggests that depression is the most common form of mental illness in older adults. For more information on the prevalence and course of depression in older adults please see Nolen-Hoeksema and Rector, 2008 p.292-294.

increases the likelihood of older persons using substances as coping mechanisms (Health Canada, 2002).

A significant number of older adults are misdiagnosed, under-diagnosed, untreated or undertreated due to the fact that health professionals misattribute substance abuse symptoms to chronic conditions such as depression, dementia and Alzheimer's disease (CAMH, 2008). In fact, McGrath, Crome and Crome (2005) state that medical professionals fail to identify up to two-thirds of older adults who have lived experience of addiction to alcohol. Potential reasons for misdiagnosis include the stereotypical expectations of older adults' behaviours that prevent health care professionals from attributing problems to substance use, a lower degree of suspicion of addiction among health care workers when assessing older adults, and a reluctance on the part of the older adult to disclose a substance use problem or seek help from others (Lin et al., 2011; Han et al., 2008; Sorocco & Ferrell, 2006; Bartels, Blow, Brockmann & Van Citters, 2005; O'Connell, Chin, Cunnningham & Lawlor, 2003; Health Canada, 2002). This finding is particularly concerning since it highlights the fact that older adults may be less likely to admit that healthcare professionals have misdiagnosed their illness and therefore are more likely to experience neglect.

**Age-related risk factors and substance abuse.** There is an abundance of literature on risk factors associated with aging and problematic substance use. Relevant risk factors include restricted access to health and healthcare, age-related biological changes that amplify the negative effects of substances, and psychosocial realities such as retirement, bereavement, losses in social networks, geographic distance from loved ones,

enabling attitudes and behaviours of others and a personal history of substance use, that can impact a person's inner fortitude and result in unhealthy coping mechanisms (CAMH, 2011; CCSA, 2011; Wu & Blazer, 2011; Clay, 2010; Roe, Beynon, Pickering & Duffy, 2010; PSSS, 2004).

**Patterns of Substance Abuse in Older Adults**

This section will review patterns of consumption and the prevalence of alcohol, illegal drugs and prescription or OTC medications in older adults.

**Alcohol.** Alcohol is the substance most commonly used by older adults (Flood & Buckwalter, 2009). According to the Public Health Agency of Canada (2010), 6 to 10% of older adults (65+) live with alcohol problems and approximately 86.5% of older adults receiving substance abuse treatment in the HNHB have an addiction to alcohol (CAMH, 2008).

Statistics from a 2004 Canadian Addiction Survey (CAS) revealed that 72% of adults aged 55 years and older used some form of alcohol in the past year (CCSA, 2005). [7] Of these older adults, 24.1% used alcohol less than once a month, 27.5% used between 1 to 3 times a month, 30.6% used between 1 to 3 times a week, and 17.9% used 4 or more times per week. [8-9] Scholars from the U.S. and United Kingdom report similar findings for alcohol use among older adults (Lin et al., 2011; McGrath et al., 2005; Oslin, 2004).

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[7] The CAS survey regarding older adults who used alcohol had a sample size of 3,751 adults aged 55 and older (CCSA, 2005).

[8] The CAS survey regarding the frequency of drinking patterns among past-year drinkers had a sample size of 2,495 adults aged 55 and older (CCSA, 2005)

[9] It is interesting to note that a much larger percentage of older adults used alcohol 4 or more times a week when compared to younger adults in the CAS study. For example, the

Patterns of alcohol consumption change as people age. In general, scholars report an age-related decline in the quantity of alcohol consumed per drinking "occasion" as well as a slight decrease in the frequency of alcohol occasions (Coulton, 2009; CCSA, 2006; Health Canada, 2002). Lin et al. (2011) suggest that a decline of alcohol use among older adults may be due to "a maturing out of abuse and dependence" or a result of increased mortality among this population that reduces their chances of reaching late adulthood (p. 297).

A review of the literature reveals that there is no international consensus on the threshold for problematic substance abuse among older adults (Lin et al., 2011; Coulton, 2009; CAMH 2007b; Health Canada, 2002). According to CAMH's "Guidelines for Low-Risk Drinking", older adults should avoid drinking more than two standard alcoholic beverages per day; and should restrict alcohol use to less than or equal to 14 or 9 standard drinks per week for men and women, respectively (CAMH, 2007b). While the vast majority of older adults drink within these guidelines, a study conducted by CCSA (2006) reported that 18% of Canadians aged 55 to 64 and 11% aged 65 to 74 exceeded the recommended low-risk limits in 2005 (Coulton, 2009). This points to a segment of the population that may require age-appropriate treatment for alcohol use that may become problematic.

Various studies have been conducted on the prevalence of alcohol dependence in older adults who live in the community and long-term care (LTC) homes as well as those who receive care from inpatient settings and mental health services (Coulton, 2009;

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study found that 3.4% of adults aged 20-24 compared to 24.2% of adult's aged 75 years and older used alcohol more than 4 times a week (CCSA, 2005).

McGrath et al., 2005; Oslin, 2004). A majority of these studies are either dated, or not based in Canada. Research suggests that there is a higher prevalence of alcohol use among older adults living in inpatient settings (psychiatric and hospital) versus those dwelling in the community[10] (Coulton, 2009; McGrath et al., 2005; Oslin, 2004).

Research on characteristics that lead to alcohol abuse is limited. Available research suggests that Caucasian[11] young-old men[12] who are married[13], have a high income and education and live in large metropolitan areas have an increased risk of abusing alcohol in later life (Lin et al., 2011; Blazer & Wu, 2009a; Blazer & Wu, 2009b; Oslin, 2004). Moreover, based on the perspectives of 29 key experts from the Health Canada (2002) study, the experience of multiple losses, loneliness, isolation and history of substance abuse are also major risk factors for alcohol abuse in later life. Additional risk factors include a history of family use, belonging to social circles that accept use, biological processes that no longer metabolize substances at the rate of younger counterparts, cognitive impairments, and mental health problems such as depression and elder abuse/neglect (Health Canada, 2002).

[10] Black and colleagues (1998) studied 865 older adults living in a Baltimore public housing project and found that 4% had a current alcohol use problem and 22% had a lifetime prevalence of alcohol use (cited in Oslin, 2004).
[11] Research findings regarding the prevalence of different ethnicities may be skewed due to cultural/linguistic barriers and the common misdiagnosis of older adults with substance use concerns.
[12] CCSA (2006) reveals that twice as many Canadian men than women exceed CAMH's Low-Risk Guidelines (30 % versus 15 %).
[13] Literature illustrates conflicting findings regarding marital status. Other scholars report divorce or separation as a key factor leading to alcohol use in older adults (Lin et al., 2011).

**Illicit drugs.** Unfortunately, there is not a significant body of literature on the epidemiology of misuse and abuse of illegal drugs among older adults. This is due, in part, to the under-sampling, under-analysis and underreporting of data on older adults with lived experience of illegal drug use in large and small scale research studies. Simoni-Wastila and Yang (2006) attribute a dearth of information on older adults as related to a lack of standard definitions for drug abuse and dependency in this population, as well as inconsistent prevalence rates that are based on a wide range of subpopulations and settings (i.e. community, LTC homes and EDs). [14]

Illegal drug use is generally perceived as an addiction for younger populations; however, research suggests that the aging of the baby boom cohort will change this current perception (Wu & Blazer, 2011; Roe et al., 2010; Crome & Bloor, 2005a). Numerous investigators have drawn attention to the high use of psychoactive substances among the baby boom generation since the 1960s. As this generation enters older adulthood it is reasonable to assume that the prevalence of psychoactive substances will increase among older adults (Wu & Blazer, 2009a).

Canadian statistics on the prevalence of drug use amongst the general population reveal that 1% of adult's aged 55 years and older use illegal substances; of these older adults, 41% use illegal substances on a monthly basis (Tjepkema, 2004). While these

[14] Levy and Anderson (2005) also suggest that current statistics may misrepresent the actual prevalence of illegal drug use in older adults. In their study of 40 in-depth interviews with early-onset, active injection drug users between the ages of 50 and 68, Levy and Anderson reported that older adults were afraid to seek help due to fear of discrimination, stigma, hospitalization and trouble with law enforcement. These findings suggest that older adults may be less likely to report an addiction or use of illegal substances in research studies due to fear of reprisal and discrimination, thus skewing results.

statistics highlight that illegal drug use is less common among older adults, more recent data suggests that it is on the rise, particularly among middle-aged and young-old adults (Wu & Blazer 2011; Beynon, Stimson & Lawson, 2010; Blazer & Wu, 2009a; Dowling, Weiss & Condon, 2008). For instance, SAMHSA (2006) reported that illicit drug use among adults aged 50 to 59 increased from 2.7% in 2002 to 4.4% in 2005, and among adults aged 55 to 59 it increased from 1.9% to 3.4% (cited in Dowling et al., 2008).

Illegal substances commonly used by older adults include cannabis, crack (crystallized cocaine) and intravenous drugs such as heroin and cocaine. CAMH (2008) reports that 5.3% of older adults (55 years and older) in Ontario substance abuse treatment programs receive care for cannabis abuse, while 4.6% seek support for crack abuse and 6.9% for intravenous drugs. In the HNHB, these figures increase slightly to 5.7% for crack use and 7.8 % for intravenous drugs (CAMH, 2008). Furthermore, Wu and Blazer (2011) list several characteristics that are associated with addiction to illegal drugs among older adults, which include unmarried status, male gender, less education, early onset of drug abuse, low-income status, experiencing a major depressive episode in the past year, disability-related unemployment, infrequent attendance of religious services and recent tobacco or alcohol use. Research conducted on the perspectives of service providers echo Wu and Blazer's (2011) findings (PSSS, 2004; Brown, 1982). According to PSSS (2004) self-neglect and estrangement from family members and loved ones were additional characteristics of older adults with lived experience of illegal drug addiction.[15]

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[15] Other investigators support these findings (Roe et al., 2010; Wu & Blazer, 2009a; Crome & Bloor, 2005a).

**Prescription drugs and OTC medications.** Concern over the use and misuse of prescription and OTC medications among older adults has risen over the past few years. Ramage-Morin (2009) reported that Canadian pharmacists dispensed an average of 35 prescriptions per adult aged 60 to 79, and 74 prescriptions among adults aged 80 years and older in 2005. The high rate of prescription use among older adults was compared to an overall national average of 14 prescriptions per person[16] (as cited in Ramage-Morin, 2009). According to the Canadian National Population Health Survey (1999), 76% of older adults living in private households admitted to using a prescribed medication two days prior to their interview (as cited in Ramage-Morin, 2009). Of these older adults, multiple medication use was common[17] and was found to be positively associated with poor health status, which has been identified as a contributing factor to misuse of prescription and OTC medications (Crome & Bloor, 2005a).

Research suggests that there are two major classes of prescription medications that are subject to abuse and dependency among older adults: opioid analgesics and benzodiazepine sedative-hypnotics (Kalapatapu & Sullivan, 2010; Simoni-Wastila & Yang, 2006). While opioids are often prescribed for older adults to relieve pain, benzodiazepines are commonly used for anxiety, stress and sleep disorders (Weekes, Rehm & Mugford, 2007; Simoni-Wastila & Yang, 2006). Research on opioid use has

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[16] A study conducted by the Conseil des aînés (2005) reports that 74% of Quebec seniors take at least 1 prescription drug over the course of a year, thus illustrating the extent of use and the potential for addiction (cited in CCSA, 2006).

[17] Ramage-Morin (2009) defines multiple medication use as the use of 5 or more different drugs in the past two days. The survey found that 53% of older adults living in LTC homes and 13% residing in private residences used multiple medications (Ramage-Morin, 2009).

shown that approximately 20% of Canadians over the age of 60 receive long-term prescriptions for pain medication, and 5.7% of older adults living in Ontario seek substance abuse treatment for a prescription opioid addiction (CAMH, 2008; Weekes et al., 2007). It is important to note that abuse of prescription medications is rare among older adults, except in cases where individuals have a history of abuse or are presently using alcohol and/or illegal drugs (Blazer & Wu, 2009a; Weekes et al., 2007; Simoni-Wastila & Yang, 2006). An interesting study conducted by Park & Lavin (2010) reported depressive symptoms and a high level of pain severity as risk factors for opioid medication misuse in a sample of 163 community-dwelling older adults with chronic pain.

On the other hand, benzodiazepines are highly addictive, and prolonged periods of use (more than 4 months) and/or high doses may significantly increase the likelihood of dependency among older adults (Simoni-Wastila & Yang, 2006). A study conducted in the province of Quebec by Voyer, Preville, Cohen, Berbiche and Beland (2010) revealed that the reported use of benzodiazepines among 2,785 randomly selected older adults (aged 65 years or older) was 25.4%. Among these individuals 9.5% met the criteria for benzodiazepine substance dependence according to the DSM-IV-TR[18]; however, investigators revealed that 43% of users reported dependence regardless of meeting the DSM-IV-TR criteria and 33% agreed on the need to refrain from benzodiazepine use (Voyer et al., 2010). Results from the study demonstrate that people who consume benzodiazepines as prescribed can experience symptoms of physical and psychological

[18] See Appendix A for the definition of substance dependence.

dependence regardless of meeting DSM-IV-TR criteria. Furthermore, in order to prevent addiction, prescriptions for benzodiazepines should be carefully monitored by a healthcare professional to mediate feelings of dependence and help older adults reduce use.

All things considered, women are 4 times more likely than men to misuse prescription and/or OTC medications (Blazer & Wu, 2011; Kalapatapu & Sullivan, 2010; Simoni-Wastila & Yang, 2006; Crome & Bloor, 2005a). The risk of dependence increases for women who are less educated, widowed, have lower income, poor health status and small social support networks (Crome & Bloor, 2005a).

According to Barnea and Teichman (1994), there are three main patterns of prescription and OTC medication misuse among older adults (as cited in Health Canada, 2002). The first is the use of medications contrary to physician instructions. This pattern of misuse is deliberate and older adults may use denial, rationalization, defocussing and minimization strategies when questioned by others regarding their misuse (Health Canada, 2002). The second pattern of misuse refers to individuals who use multiple medications that result in an adverse drug event. This often occurs when individuals receive medications from more than one physician, or fail to report OTC medications to physicians prior to receiving prescriptions. The third pattern of misuse occurs from misinformation and misunderstanding (Health Canada, 2002). This pattern of misuse includes adults who forget to take their medications, take double doses to “make up” for their forgetfulness, take medication at the wrong time, ingest improper amounts, misunderstand prescription instructions, are unable to read instructions and neglect to

refill prescriptions due to insufficient funds or the belief that medication use is not necessary (Health Canada, 2002).

**Treatment**

The following section will explore literature on the treatment needs of older adults. It will begin by briefly describing the concept of "age-specific" interventions, and the need for program flexibility/tailored treatment to address the age-related health and social circumstances of older adults. This section will also review literature on addiction treatment settings, philosophies and best practice approaches to attaining recovery among older adults. This section will conclude with a brief analysis of existing literature on the treatment barriers older adults encounter and recommendations for reducing barriers.

**Age-specific interventions.** Over the years, scholars have debated the addiction treatment needs of older adults. Research in the 1980s focused mainly on the transferability and effectiveness of mainstream treatment approaches for older adults, whereas the 1990s saw a shift in focus which compared the outcomes and effectiveness of age-specific versus mainstream or mixed-age interventions (Health Canada, 2002). While more recent literature has focused on the benefits of tailoring treatment to address the age-related life experiences of older adults, it is important to begin by briefly noting research that exists on age-specific interventions.

According to SAMHSA (1998), age-specific treatment is a form of group treatment geared towards the needs of older adults. There are two main formats for providing age-specific treatment: the first entails the provision of a discrete program that offers age-specific services exclusively for older adult clients; the second option refers to

the delivery of age-specific groups for older adults that exist within mixed-age treatment programs (SAMHSA, 1998). The literature suggests that the use of either format produces positive results for older adults (Kofoed et al., 1987; Oslin, 2004; Oslin, Pettinati & Volpicelli, 2002).

A study conducted by Kofoed et al. (1987) compared treatment compliance between 24 older adults enrolled in a mixed-age treatment program and 25 older adults enrolled in an age-specific treatment program. Results of the study found that individuals enrolled in the age-specific program remained in treatment longer and were more likely to complete their treatment program when compared to individuals in the mixed-age treatment setting. In addition, Oslin (2004) reported that older adults assigned to an elder-specific treatment program were 2.9 times more likely at 6 months and 2.1 times more likely at 1 year to abstain from alcohol use when compared with older adults in mixed-age treatment programs. [19]

Moreover, a study conducted by Oslin et al. (2005) observed patterns of adherence to treatment between 40 older and 143 younger adults. The study reported that older adults could be effectively treated in a mixed-aged setting as long as age-appropriate psychotherapeutic strategies were used on an individual basis. [20]

While there is evidence to support the effectiveness of either format the fundamental importance of providing age-specific treatment is such that age-specific approaches explicitly address addiction issues congruent with the older adult's life-stage

[19] Similar findings were reported by Dowling et al. (2008); Blow et al. (2000); and Atkinson, Tolson and Turner (1991).
[20] Similar findings were reported by Lemke and Moos (2002); Fareed et al. (2009); Sorocco and Ferrell (2006); Satre et al. (2004); and Satre et al. (2003).

(Colleran & Jay, 2002; SAMHSA, 1998). In other words, younger and older adults may share in the experience of being addicted to a substance; however, the underlying cause and reason for abusing the substance will be dissimilar, thereby necessitating different approaches to address the addiction[21]. For example, older adults may recognize problems faced by their younger counterparts (such as job loss and child custody) but no longer find them relevant, just as younger adults, with no experience of growing older, may be impatient or lack empathy for older adults who may be dealing with cognitive and physical decline, widowhood and shrinking social networks (Rothrauff, Abraham, Bride & Roman, 2011; SAMHSA, 1998).

In addition, older adults may feel more comfortable in treatment with people of their own generation due to the fact that substance abuse carries a negative connotation, both personally and socially. This is often the reason why scholars note the importance of providing addiction treatment to older adults that is supportive, builds self-esteem and social networks, as opposed to confrontational treatment approaches that require the older adult to accept the stigmatizing and shameful title of, for example, an "alcoholic" (Wu & Blazer, 2011; Dowling et al., 2008; Sorocco & Ferrell, 2006; Health Canada, 2002; Oslin et al., 2002; Kennedy et al., 1999). Moreover, older adults may appreciate the fact that their peers have experienced the same social and historical life events. Also, older adults may benefit from a slower paced environment that fosters the feeling of having more time to "tell their story," which can be especially helpful for individuals who are not

[21] According to Colleran and Jay (2002), needs, perceptions and lifestyles also vary between younger and older adults with substance use problems.

accustomed to sharing personal and sensitive issues with others (Health Canada, 2002, p.39).

While there are many noted benefits to providing age-specific treatment for older adults, a majority of treatment programs do not offer these services, perhaps in part, due to funding and organizational barriers. In the absence of age-specific treatment, SAMHSA (1998) recommends that mixed-age programs group older adults with younger individuals who have similar lifestyles, problems and substance issues; and furthermore, suggests that these programs hire staff with training or an interest in working with older adults (Wu & Blazer, 2011; Health Canada, 2007).[22]

***Tailoring treatment.*** Effective service delivery relies on the flexibility of treatment programs that address and support the unique strengths, weaknesses and healthcare needs of older adults (Health Canada, 2002). While substance abuse may be a consequence of, or a precursor to, physical and/or cognitive impairment, it is nonetheless imperative for practitioners to address and be sensitive to the healthcare needs of older adults prior to successfully treating problematic substance use (Health Canada, 2002). For example, it is common for older adults to experience reduced mobility and stamina and require more time for transitioning through different levels of treatment, grasping new concepts and feeling comfortable to open up and share feelings with others (Rosen, Hunsaker, Albert, Cornelius & Reynolds, 2011; Colleran & Jay, 2002). Thus, treatment

[22] Zimberg (1996) lists three steps necessary to providing an age-specific approach for seniors. These include: the implementation of holistic client-centered approaches to identify and deal with age-related stresses (such as deteriorating health, retirement, relocation etc.); an accurate diagnosis to rule out other factors (such as psychiatric comorbidity) that may affect treatment outcome; and, encouraging older adults to expand social networks, and create and self-identify with new roles that are meaningful.

should be tailored to accommodate a longer length of stay and a slower pace for older adults (Rosen et al., 2011; Health Canada, 2007; Colleran & Jay, 2002).

In addition, older adults with vision or hearing problems may benefit from tailored treatment that provides larger print material, better lighting and respectful hearing levels (Rosen et al., 2011; Health Canada, 2007; Health Canada, 2002). Individuals who are physically unable to transport themselves may also benefit from in-home visits or easily accessible transportation to and from treatment programs (Rosen et al., 2011; Health Canada, 2002). Older adults who feel stigmatized or uncomfortable with sharing personal stories may benefit from individualized therapy, direct involvement in treatment planning and access to practitioners that value the art of actively listening to their needs, treating them with respect, involving family members in their care plan (with their consent), showing an interest in their general wellbeing and expressing a belief in their ability to fully recover (Rosen et al., 2011; Health Canada, 2007; Colleran & Jay, 2002; Oslin et al., 2002; SAMHSA, 1998).

Health Canada (2002) states that it is also important for practitioners to recognize and respect the individual's socio-cultural environment. This includes views on substance use from a religious, cultural and age cohort perspective. For instance, some cultures and religious backgrounds may have a more restrictive view of substance abuse and this may affect the older adult's willingness and openness to certain treatment approaches. For this reason, among others, it is important for practitioners to consider these views and involve older adults when developing treatment plans (Health Canada, 2002).

**Addiction treatment settings.** According to CAMH (2009), substance use treatment services funded by the Ontario Ministry of Health and Long Term Care (MoHLTC) are required to use standardized admission and discharge criteria from a set of standardized assessment instruments to place clients in appropriate treatment settings. Criteria used for client placement is based on the strengths and needs of clients in the following seven categories: acute intoxication and withdrawal needs[23], medical and psychiatric needs[24], emotional and behavioural needs[25], treatment readiness[26], relapse potential[27], recovery environment and supports[28] and barriers and resources[29] (CAMH, 2009). Based on results from this assessment, older adults are placed into different levels of treatment, ranging from high intensity medically managed inpatient treatment to low intensity outpatient treatment services.

[23] Acute intoxication and withdrawal needs refer to whether individuals require withdrawal management services and, if so, the level of care and attention that is needed (CAMH, 2009).
[24] Medical and psychiatric needs refer to the presence of (and need to stabilize) acute or chronic medical or psychiatric problems that run the potential of interfering with participation in treatment (CAMH, 2009).
[25] Emotional and behavioural needs refer to the client's overall skill level and functioning ability for daily living activities (CAMH, 2009).
[26] Treatment readiness is assessed using the stages of change model, which determines the intensity, and level of treatment (CAMH, 2009).
[27] Relapse potential refers to the likelihood that the individual will relapse and the level of treatment support that is needed to help the individual achieve his/her treatment goals (CAMH, 2009).
[28] Recovery environment and supports refer to the level of support and safety a client has within his living environment. This helps to determine whether the individual requires residential or more intensive treatment (CAMH, 2009).
[29] Barriers and resources refer to potential barriers that may interfere with an individual's participation in treatment and the resources an individual may have or need to overcome potential barriers (CAMH, 2009).

SAMHSA (1998) identifies four basic levels of addiction treatment for older adults with substance use concerns. The first, and least intensive treatment setting is known as outpatient treatment. It can be offered in various places in the community, such as health clinics, community mental health clinics, hospital clinics, or residential programs with outpatient clinics (SAMHSA, 2004). This treatment option provides addiction services at a central program site to individuals living in the community (SAMHSA, 2004). Individuals enrolled in an outpatient treatment program may receive outpatient care that ranges from one group session per week and one individual session per month to day-long treatment 5 days a week or two to three hours of treatment per day depending on the individual's assessed need (SAMHSA, 1998). Individuals enrolled in outpatient treatment often have little risk for medical complications, are willing to attend counselling sessions, have transportation to and from the outpatient program, have a low relapse potential as well as a place to live and good social support (Clay, 2010; SAMHSA, 2004).

The second basic level of addiction treatment for older adults is called residential treatment. This program provides individuals with a living environment while they receive addiction treatment services. This model is ideal for individuals who lack stable housing and/or employment and/or familial and social support (SAMHSA, 2004; SAMHSA, 1998). Individuals with very serious substance use disorders who have been unsuccessful in other programs to "stay sober" or "drug-free" often benefit from this type of program, which can last anywhere from one month to a year or more in duration (SAMHSA, 2004; SAMHSA, 1998, p.6).

The third level of addiction treatment for older adults is known as inpatient rehabilitation/medical treatment. This level of treatment is offered in special units of hospitals and can last anywhere from 14 to 28 days (SAMHSA, 2004; SAMHSA, 1998). According to SAMHSA (1998) individuals who are "brittle, frail, acutely suicidal or medically unstable or who need constant one-on-one monitoring" should have access to 24-hour primary psychiatric/medical/nursing inpatient care within a medically monitored and managed intensive inpatient treatment setting (SAMHSA, 1998, p.6).

The fourth, and final level of addiction treatment for older individuals is known as outpatient/inpatient withdrawal management treatment. One of the first issues to consider during assessment is whether or not the older adult requires withdrawal management and, if so, whether withdrawal can be managed on an outpatient basis or in an inpatient hospital-based setting (SAMHSA, 1998). When compared to younger adults, withdrawal is viewed as medically riskier and thus should be treated with caution. In order to avoid or reduce negative side effects, practitioners in withdrawal management units slowly taper with the dosages of medications to help older adults withdraw safely from problematic substance use (Clay, 2010). In general, older adults who have suicidal ideation, comorbid psychopathology, unstable medical conditions, mixed addictions, few social supports, a history of not responding to outpatient treatment and a high likelihood of developing dangerous abstinence symptoms require inpatient withdrawal management (Clay, 2010; SAMHSA, 1998).

**Treatment approaches and philosophies.** There are several different types of treatment approaches and philosophies used in the field of addiction, including: brief

interventions, motivational interviewing, cognitive behavioural approaches, group-based approaches, family involvement, narrative therapy, individual therapy, outreach and pharmacological interventions. For information on the effectiveness of best practice treatment approaches and philosophies for older adults with substance use concerns, refer to Appendix B.

**Barriers to addiction treatment.** Existing research highlights 5 main barriers to treatment and rehabilitation for older adults, including personal barriers, interpersonal barriers, community/cultural barriers, structural/program barriers and education barriers. According to key experts from Health Canada's (2002) study, personal barriers that impede an older adult's decision to access treatment include: feelings of shame, a lack of awareness of programs and/or the presence of addiction, transportation barriers such as mobility issues and sensory limitations that impact hearing and/or vision. In terms of interpersonal barriers, key experts identify the role of family members in enabling use by denying the presence, and avoiding the topic of a substance use problem (Health Canada, 2002). Moreover, key experts identified a fear of shame, loss of status, independence and damaged relationships as additional interpersonal barriers that deterred older adults from seeking treatment and rehabilitation services (Health Canada, 2002). Community barriers included a fear of stigmatization from community members, limited transportation and threats to confidentiality, particularly in rural areas (Health Canada, 2002). In addition, cultural barriers included the barriers between clients and clinicians, a lack of cultural sensitivity in agencies, and cultural norms that either accepted or ignored alcohol use, or regarded substance use problems as private family matters (Health Canada, 2002). With

respect to structural/program barriers, key experts in the Health Canada (2002) and PSSS (2004) study highlighted a lack of age-specific programming, limited transportation services, limited roles of physicians and pharmacists, and insufficient resources and treatment options such as early intervention programs and outreach teams. Moreover, service providers from the PSSS (2004) and Schonfeld et al. (1994) study reported on education barriers, which highlighted limited knowledge on effective screening/ assessment tools, and a lack of prevention/education resources for older adults, service providers, family members and the broader community.

Interestingly, a lack of training opportunities for identifying substance use concerns among older adults has been identified as an additional knowledge barrier. Schonfeld and colleagues (1994) revealed that less than half of the 296 service providers who completed their questionnaire received staff-development or in-service training related to the treatment needs of older adults with an addiction; thus confirming a lack of training opportunities for service providers. Additionally, PSSS (2004) revealed that of their 60 respondents, only 6 (10%) reported that training related to substance abuse among older adults was provided by their organization.

While the barriers identified by Health Canada (2002), PSSS (2004) and Schonfeld et al. (1994) are comprehensive and provide a strong foundation from which to extend existing literature, their effectiveness is limited by the fact that they are dated and require additional research in order to assess the validity and persistence of these barriers in 2012 as well as identify whether these barriers have been addressed through new provincial, regional or local initiatives.

**Recommendations for reducing treatment barriers.** Based on previous research, there are several common themes regarding recommendations for reducing addiction treatment barriers for older adults (Andrews, 2008; PSSS, 2004; Health Canada, 2002; Schonfeld et al., 1994; Brown, 1982). To begin, enhanced education and training opportunities have been identified as a common recommendation for improving access to services; reducing stigma and discrimination among older adults, family members, health care/ service providers, the general public and policy makers; providing service providers with the tools and knowledge necessary to conduct effective assessments, interventions and follow-up procedures; and to increase awareness of existing service options in different communities (PSSS, 2004; Health Canada, 2002; Schonfeld et al., 1994; Brown, 1982).

Key experts also recommend the use of age-specific care for older adults. Recommendations for age-specific care include the delivery of services in a non-stigmatizing, non-confrontational, flexible and adaptable manner as well as the employment of holistic practices that recognize individual strengths, goals, weaknesses and realities while adopting harm reduction principles of care or alternatively, providing a slower paced treatment plan for older adults enrolled in abstinence-based treatment programs (Andrews, 2008; PSSS, 2004; Health Canada, 2002; Brown, 1982). Moreover, an age-specific approach to care is cited as a potential solution to reducing problematic barriers identified by older adults and would furthermore focus on improving their overall quality of life. Service providers also argue that age-specific treatment addresses the discomfort seniors feel with mixed-age group participation by providing opportunities for

individualized treatment, offering age-specific group treatment and involving family members, friends and caregivers in treatment as members of the senior's support network (when approved by the older adult) (Andrews, 2008; PSSS, 2004; Health Canada, 2002; Brown, 1982).

Another common theme revolved around the provision of culturally appropriate services. According to Andrews (2008), services should "ensure that treatment programs are culturally and linguistically appropriate" (p. 102). Moreover, staff members need to receive training on the cultural norms and meanings regarding substance use to be culturally sensitive to the needs of older adults from different ethnicities (Andrews, 2008). In addition, service providers from the Health Canada (2002) study recommended that services create buddy systems for people to overcome obstacles related to cultural differences in treatment. Buddy systems partner older adults from similar backgrounds to provide support for each other during treatment (Health Canada, 2002).

Service providers also identified the need for programs to collaborate with other services in order to provide a comprehensive continuum of services (Andrews, 2008; PSSS, 2004; Health Canada, 2002). It was recommended that programs employ multidisciplinary teams to assess and treat substance use concerns as well as other physical and mental health issues. Additionally, service providers recommended the use of outreach teams to address barriers by meeting seniors at their place of residence to increase comfort levels, reduce transportation barriers and fear of discrimination and stigma (PSSS, 2004; Health Canada, 2002).

# METHODOLOGY

The following section will review the methodological tools used for this research study. It will begin by describing the research design, followed by the study sample, sampling procedures, research methods, ethics process, thematic analysis and rigor.

**Research Design**

A descriptive qualitative research design was used to gather data on the perspectives of 24 addiction service providers on the topic of older adults with substance use concerns. Data were collected over a three-month time frame, from November 2011 to January 2012. Semi-structured personal interviews were conducted to gather rich data on provider's perceptions of addiction services for older adults in Hamilton, Ontario.

According to Dr. John Gerring (2001), a well-known author of literature on social science methodology, descriptive research is interested in two empirical questions: "what is out there" and "what will we call it" (p.156). In line with Gerring's interpretation of descriptive research, this study aims to address the former question by exploring the addiction services that currently exist, the basic characteristics and unique needs of older adults with substance use concerns, the barriers they encounter when they require addiction treatment and recommendations for addressing barriers moving forward. This research study aims to advance the current state of knowledge on this topic by reporting findings that adhere to the data and establishing a connection between findings and existing literature on older adults with addiction concerns. This research will serve as the foundation for future research that will look at implementing strategies that improve access to addiction treatment for individuals aged 50 years and older.

**Study Sample**

The sample included managers/administrators and front-line workers from addiction services. Managers/administrators included individuals who manage the day-to-day operations of addiction agencies/organizations in Hamilton, Ontario. Positions of participants included executive directors, coordinators and clinical directors. Front-line workers included individuals who worked directly with people using addiction services. This cohort included case managers, social workers and counsellors.

**Inclusion/exclusion criteria.** Participants were employed by an addiction treatment agency/organization located in Hamilton, Ontario. Services were located in the community or within hospitals, and provided treatment for abuse of legal and illegal substances. Agencies/organizations that provided additional services for addiction gambling, tobacco, and mental health treatment were included in the study population; however, the focus of interviews were specifically geared toward alcohol, prescription and OTC medications and illegal substances for older adults. A few agencies/organizations in the study had multiple addiction programs that were geared toward different populations and needs. In order to reflect the variety of services, results from each program were analyzed and coded on an individual basis. Services that were excluded from the study included agencies/organizations that were geared specifically for youth, self-help groups such as Alcoholics Anonymous (AA), and primary care clinics. Self-help groups were excluded from the study primarily due to insufficient time and resources as well as the organizational values of anonymity for people who attend self-help groups such as AA.

**Sampling Procedures**

**Purposive sampling.** Study participants were recruited using the non-probability sampling procedure known as purposive sampling (see Patton, 1990). According to Neutens and Rubinson (2002), purposive sampling is the process of selecting a particular group of people or cases that meet the purpose of a study. Patton (1990) argues that the logic and power of purposive sampling rests in the selection of “information-rich cases” that generate a great deal of information on the issues of central importance to the purpose of one’s research (p.169).

In order to provide a system perspective of Hamilton addiction service providers, it was necessary for participants to be employed by Hamilton-based agencies/ organizations that provided services for people with substance use concerns. In addition, it was important to recruit service providers from different occupations (managers/ administrators and front-line workers) in order to broaden the scope of the research study and provide a more comprehensive perspective of addiction services for older adults.

**Recruitment of study participants.** To identify agencies/organizations that met inclusion and exclusion criteria, the community database *Inform Hamilton* was consulted. *Inform Hamilton* is an online database that provides easy access to more than 4,000 information records of government, community, voluntary sector, non-profit and health sector programs and services in Hamilton (Inform Hamilton, 2011).

Using the simple keyword search on the *Inform Hamilton* homepage, the phrase “addiction service” was used to identify organizations and potential study participants. The keyword search recognized 47 potential organizations/programs that provided

addiction services. Of these addiction services, 14 organizations met the inclusion and exclusion criteria of the study[30] and representatives from 10 out of 14 organizations voluntarily participated in the study, thus securing a fairly representative sample population of addiction services in Hamilton.

Strategies to recruit managers/administrators differed from recruitment strategies for front-line workers. Managers/administrators were recruited via email and a follow-up telephone conversation. Contact information was gathered using readily accessible contact information listed on *Inform Hamilton* and public websites, such as the Drug and Alcohol Registry of Treatment (DART) website. Managers/administrators were listed as primary or alternate contact persons for their organization on *Inform Hamilton's* community database. Recruitment emails included information on the purpose of the study as well as the role of potential study participants. The recruitment email also included the letter of information and interview guide as attachments to help participants not only make an informed decision on whether or not to participate in the study, but also to give participants time to review and reflect on the interview questions in hopes of generating a comprehensive and truthful discussion of questions during the interview (see appendix C and D for the recruitment email and letter of information, respectively).

Moreover, the email informed participants that their participation was completely voluntary and that information shared during the interview process would be kept

[30] In order to ensure that potential organizations and programs met the study's inclusion criteria, I conducted a close examination of the populations served, as well as the description of services provided and location of services in the community by reviewing information provided by Inform Hamilton as well as other online websites of organizations.

anonymous. A follow-up telephone conversation took place five business days after the email was sent to answer questions, provide more information on the study, seek their voluntary participation and set up a time and location for the interview.

Following the interview with managers/administrators, front-line workers were recruited by asking managers/administrators to forward a recruitment email to, or share a printed flyer with front-line employees. The recruitment email/flyer for front-line employees provided information on the purpose of the study and their roles as participants. It included the letter of information and the interview guide as attachments, and asked front-line employees to contact the researcher if they were interested in participating in the study.

**Research Methods**

Semi-structured personal interviews were conducted in person with twenty-four study participants from 10 agencies/organizations. Face-to-face interviews took place at the participant's place of employment. The researcher conducted interviews with participants that ranged from 32 minutes to 128 minutes and the average length of each interview was approximately 60 minutes. With permission from participants, data were collected using a tape recorder and handwritten notes. The tape recorder was used to ensure that research findings would accurately reflect interview discussion and the perspectives of participants. Handwritten notes were used to identify key points of discussion during interviews. This was beneficial for two main reasons; firstly, handwritten notes ensured a smooth transition between interview questions and thus helped to maximize discussion during interviews, and secondly, notes were used as an

initial step for identifying codes in the transcripts and themes of the study. Initial codes were reviewed and revised during the analysis of transcribed interviews. At the special request of two study participants, one interview was conducted with two persons present; the remaining 22 interviews were conducted on an individual basis.

**Interview questions.** The interview guide included a series of open-ended questions and gathered demographic information (see appendix E for the interview guide). Interview questions were created based on existing literature on the perspectives of service providers regarding substance use concerns among older adults. Results from Schonfeld et al. (1994), Andrews (2008), Partners Seeking Solutions with Seniors (2004), Brown (1982), and Health Canada (2002) were consulted during the process of developing interview questions and pursuing areas in need of future research. The interview guide included questions pertaining to (a) the current provision of addiction services for older adults, (b) characteristics of older adults (c) perceived barriers to treatment and areas in need of improvement, and (d) recommendations for addressing the needs of older adults in addiction treatment.

Following completion of interview questions, participants were asked to provide information regarding their agency's setting, treatment location, job title/agency role, academic background and years in the addiction field. This information was gathered to provide a profile of agencies and research participants involved in the study.

**Ethics**

The McMaster University Research Ethics Board (MREB) approved this study on October 19th, 2011 (see appendix F for certificate of ethics clearance). During the

recruitment stage, study participants went through the process of informed consent and had access to the letter of information/consent form and the interview guide prior to the interview. This was to ensure that study participants were fully informed of the purpose and procedures of the study as well as their role as participant prior to giving consent and conducting the interview. Study participants signed to give consent and were informed of their right to withdraw, without consequences, from the study at any time, including after they had signed the consent form or partway through the study.

With regards to confidentially, study participants were informed that all identifying information, including their name and agency, would be replaced with pseudonyms and acronyms in the interview transcripts and the study. Participants were aware that the information they provided would be summarized with the information provided by other participants and that all information would be kept in a locked cabinet and password protected computer.

**Thematic Analysis**

Following the verbatim transcription of interviews, the researcher analyzed the perspectives of service providers using a thematic approach. According to Braun and Clarke (2006), thematic analysis is “a method for identifying, analyzing and reporting patterns (themes) within data” (p. 79). It entails the active search and identification of patterns and themes as well as the creation and application of codes to the *data set* to determine common themes and patterns of meaning (Braun & Clarke, 2006; Neutens & Rubinson, 2002). As noted by Braun and Clarke (2006), a thematic analysis offers a more flexible and accessible method of analysis that can prove particularly useful for

individuals who are early in their qualitative research careers. Consistent with Braun and Clarke's (2006) useful explanation of thematic analysis, this study aimed to provide a rich thematic description of the 24 interviews (*data set*) conducted with addiction service providers by identifying, coding and analyzing important semantic themes that were strongly linked to the data themselves.

**Key phases of thematic analysis.** Braun and Clarke (2006) describe 6 key phases of thematic analysis including: becoming familiar with the data, generating initial codes, searching for themes, reviewing themes, defining and naming themes and producing the report. The current research study will employ Braun and Clarke's (2006) phases of thematic analysis as an outline for analyzing the data and establishing themes.

***Becoming familiar with the data.*** According to Braun and Clarke (2006), it is vital that one becomes familiar with the "depth and breadth of the content" of the data set (p. 87). In order to become more familiar with the data, the researcher transcribed the 24 interviews verbatim, ensured accuracy by checking transcriptions against original audio recordings, reviewed handwritten interview notes and read through transcriptions once before actively reading through transcripts a second time to search for meanings and take notes on patterns and themes. Handwritten interview notes were compared with notes taken during the review of transcriptions in order to ensure consistency of themes and patterns.

***Generating initial codes*.** Braun and Clarke (2006) note that phase two of thematic analysis involves the creation of initial codes from the data. Coding refers to "the creation of categories in relation to the data; the grouping together of different

instances of datum under an umbrella term that can enable them to be regarded as 'of the same type'" (Gibson, 2006, p. 1). In order to organize data into meaningful groups, the researcher initially coded the data manually and later coded the data using the NVIVO software program. The researcher reviewed all transcriptions *(data set)* giving equal attention to each transcription *(data item)* while identifying potential themes across the data set. The researcher manually coded by writing notes on printed data items as well as using post-it notes and highlighters, and creating a separate document that included a list of patterns and themes found within the data set. The researcher later used NVIVO to code data by highlighting chunks of data *(data extract)* within each data item to identify and extract themes and patterns (see Appendix G for codes).

***Searching for themes.*** According to Braun and Clarke (2006), this phase "re-focuses the analysis at the broader level of themes, rather than codes, involves sorting the different codes into potential themes, and collating all the relevant coded data extracts within the identified themes" (p. 89). In order to identify themes, the researcher reviewed all codes and grouped similar codes in search of overarching themes. The researcher looked for themes that captured important information that answered at least one of the four research questions of the study, and analyzed potential themes in terms of how they were related to one another, for example identifying themes and subthemes of the data (see Appendix G for themes). Codes that did not fall within specific themes were identified as miscellaneous themes and were reviewed later to determine their relevance to the overarching research questions. In accordance with Braun & Clarke's (2006) guidelines, the researcher also created mind-maps to visualize themes and subthemes

(themes-within-a-theme) of each research question in order to narrow down and define individual themes and establish “candidate themes” (p. 91; see Appendix H for mind maps).

***Reviewing themes.*** During this phase, it is important to ensure that data within themes “cohere together meaningfully,” while also confirming that there are “clear and identifiable distinctions between themes” in order to create an acceptable thematic map (Braun & Clarke, 2006, p. 91). Thus the researcher reviewed all coded extracts within each theme to consider whether the data extract formed a coherent pattern. In cases where the coded extracts did not form a coherent pattern, the researcher assessed whether individual data extracts did not fit within the theme, belonged elsewhere, or did not belong in the analysis. During this process, some themes were dropped from the analysis and/or combined to form larger, more inclusive themes with subthemes to ensure that patterns had clear distinctions.

***Defining and naming themes.*** In this phase, Braun and Clarke (2006) recommend that researchers identify the “essence” of each theme (and overall themes) and determine “what aspect of the data each theme captures” (p. 92). In order to determine the essence of each theme, the researcher reviewed the collated data extracts of each theme and organized them to fit into the broader overall “story” of the data. In this phase, the researcher confirmed whether themes had sub-themes in order to finalize the thematic map. The researcher then reviewed data extracts within each theme to identify punchy, concise names for each theme.

***Producing the report.*** According to Braun and Clarke (2006), the write-up of any thematic analysis strives to tell the reader "the complicated story" of ones data in a way that convinces the reader of the validity and merit of ones analysis. In order to provide a logical, concise, coherent and interesting account of the data, the researcher chose vivid examples to support findings, themes and the overall argument of the research questions of the study.

## Rigor

In order to increase the validity and accuracy of research findings, the researcher kept a reflexive journal that included regular reflective entries during the interview process and analysis phase of the study. It included information on interesting findings, key themes and patterns, methodological decisions and the logistics of the study (Braun & Clarke, 2006). Moreover, the researcher transcribed interviews in order to gain a strong understanding of the verbal and nonverbal data. The researcher also reviewed the data several times to code for as many potential themes as possible; and moved "back and forth between the entire data set, the coded extracts…and the analysis of the data" to ensure coherence, consistency and distinctions between and within themes and patterns (Braun & Clarke, 2006, p. 86).

# RESULTS AND A DISCUSSION OF FINDINGS

The main objectives of the study were to confirm and expand on existing literature regarding older adults and addiction by (a) examining the perspectives of addiction service providers, (b) identifying recommendations in order to build on system strengths and respond to gaps in services, and (c) increase awareness among service providers to encourage future planning for enhancing care that specifically addresses the unique needs of older adults. In order to fulfill objectives, this study explored 4 research questions, thus gaining a clearer understanding of the perspectives of addiction service providers regarding (1) the addiction services currently being provided for older adults with addiction concerns, (2) the unique characteristics and treatment needs of older adults with substance use concerns, (3) barriers that older adults encounter when in need of care for addiction, and (4) recommendations for improving the current system to address the needs of older adults.

This section will present results from this study and explore how it has contributed to existing literature on older adults with addiction concerns. Results and discussion will be separated into 5 subheadings: (1) the characteristics of study participants, (2) the characteristics of programs, (3) the characteristics of older adults with substance use concerns, (4) the barriers to addiction services, and (5) recommendations for addressing barriers and improving the current state of addiction services for individuals aged 50 years and older.

**Characteristics of Study Participants**

Demographic questions from the interview guide gathered data on participant roles and responsibilities within agencies/organizations, education levels, years at their current agency/organization and years in the addiction or mental health and addiction field. This section will report and discuss findings on these demographic characteristics.

In terms of roles and responsibilities, a total of 24 individuals (6 male and 18 female) participated in the study. Of these individuals, 71% (n=17) reported managerial/administrative roles and responsibilities that included tasks such as supervising staff members, developing programs, managing the budget and overseeing the day-to-day operations (see Table 1). The remaining 29% (n=7) assumed front-line roles and responsibilities, which included providing direct support to clients, leading individual and/or group counseling sessions with clients, participating in referrals to other agencies, assessment and outreach services.

Table 1: Participant Roles and Responsibilities

| *Roles/Responsibilities* | *Number of Participants (n)* | *Percentage* |
|---|---|---|
| Administrative | 17 | 71% |
| Front-line | 7 | 29% |
| TOTAL | 24 | 100% |

It is important to note that 46% (n=11) of individuals who identified managerial/administrative roles and responsibilities also described additional involvement in activities that were typical of the roles and responsibilities of front-line workers. In some cases, managerial/administrative job descriptions included front-line support and direct involvement with clients on a regular basis (n=5). In other cases, front-line support was described as an additional role that was separate from their job description. Reasons

for providing front-line support as an additional service included: advocating for clients with team members, addressing client gender preferences, providing professional expertise to address medical concerns, assisting short-staffed programs and addressing concerns from front-line workers regarding poor client attendance.

With respect to education levels, all participants completed a secondary level of education. Table 2 demonstrates the highest level of education attained by study participants, with 29% (n= 7) of participants attaining a graduate level education in the academic fields of psychology, psychiatric rehabilitation, health science and social work. Moreover, 46% (n=11) of participants completed a post-secondary undergraduate degree in a variety of academic fields that ranged from the humanities to the social and health sciences. Furthermore, findings revealed that 21% (n=5) of participants received a post-secondary college diploma in fields such as social service work, addiction and practical nursing; and 4% (n=1) completed post-secondary courses in addiction counseling. A majority of participants reported involvement in continuing education opportunities, including workshops, courses and certifications on addiction, counseling and leadership building skills.

Table 2: Highest Level of Education Attained by Participants

| *Academic Background* | *Number of Participants (n)* | *Percentage* |
|---|---|---|
| Graduate Degree | 7 | 29% |
| Undergraduate Degree | 11 | 46% |
| College | 5 | 21% |
| Courses | 1 | 4% |
| TOTAL | 24 | 100% |

A majority of participants (58%) reported 10 or fewer years working at their current agency/organization (see Table 3). It is significant to note that a quarter of the sample reported working at their current agency/organization for 15 ½ years or more. Of the 10 individuals who reported employment at their current agency for 10 ½ years or more, 9 individuals described their roles and responsibilities as administrative, thus illustrating a relationship between a greater number of years spent at one agency/organization leading to the greater likelihood of attaining administrative roles and responsibilities.

Table 3: Number of Years Employed by Agency/Organization

| *Years at Agency/Organization* | *Number of Participants (n)* | *Percentage (%)* |
|---|---|---|
| 5 years or less | 7 | 29% |
| 5 ½ to 10 years | 7 | 29% |
| 10 ½ to 15 years | 4 | 17% |
| 15 ½ + years | 6 | 25% |
| TOTAL | 24 | 100% |

Due to the concurrent nature of addiction and mental health, several study participants (n=9) identified their field as "mental health and addiction". Of these individuals, the average number of years in the mental health and addiction field were approximately 23 years and ranged from 6 to 43 years of involvement. Of the 15 remaining study participants, the average number of years in the addiction field ranged from 4 to 30 years, with an average of approximately 14 years per person. Additionally, 4 individuals reported a history of, or current involvement in other fields, including the homelessness sector, long-term care services and culturally specific programs.

## Characteristics of Programs

A total of 10 agencies/organizations participated in the study; 3 agencies had multiple programs that met inclusion criteria and thus representatives from their programs were invited to participate in the study. This resulted in a study sample that included representatives from a total of 15 programs from 10 agencies/organizations in Hamilton, Ontario.

The following section will provide results and a discussion on the characteristics of programs involved in the study. Questions from the interview guide captured data on the treatment setting and location, program approaches and philosophies, and services tailored to specific needs or characteristics, such as age and sex.

**Treatment setting.** Based on programs involved in the study, Hamilton's addiction system includes a variety of treatment settings that cater to intensive and less intensive needs. Potential treatment settings included outpatient, inpatient, medical and residential programs as well as crisis outreach and consumer survivor initiatives (CSI). As demonstrated in Table 4, a majority (n=10) of programs in the study offered outpatient support for clients. According to SAMHSA (1998) outpatient treatment is the least intensive addiction treatment setting used primarily for individuals that have a low relapse potential, little risk for medical complications and live independently within the community.

Table 4: # of Programs that Offer Different Treatment Settings

| *Treatment Setting* | *Number of Programs (n)** |
|---|---|
| Outpatient | 10 |
| Residential | 6 |
| Outreach | 5 |
| Medical | 1 |
| Inpatient | 1 |
| CSI | 1 |

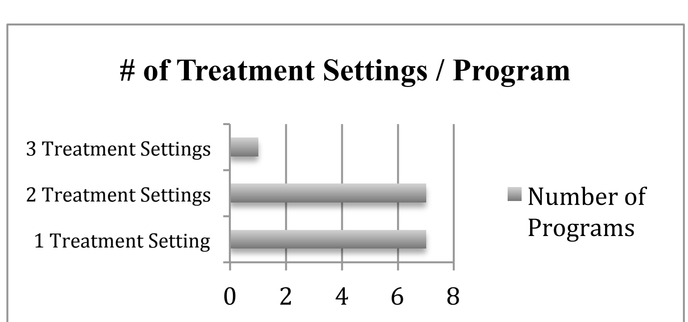
* Programs do not add to 15 because some agencies provide more than one program.

Residential and outreach settings were also common among Hamilton addiction agencies/organizations with 6 and 5 programs offering those services, respectively. It is important to note that of the 5 programs that identified outreach support as one of its services, outreach was seen as uncommon and rarely provided due to time and resource constraints.

While the Hamilton addiction system provides access to varying degrees to residential treatment, outreach, medical care, inpatient care, and CSIs it lacks an inpatient rehabilitation/medical treatment program geared specifically toward individuals with addiction concerns. This illustrates a potential gap in services for older adults since they are more likely than their younger counterparts to experience medical complications during withdrawal; therefore, may be more likely to benefit from an inpatient rehabilitation program or increased access to medical care in community settings (Clay, 2010; Health Canada, 2002).

Moreover, several programs reported that they provided more than one treatment setting per program. Figure 1 illustrates that of the 15 programs, 47% of programs provided 1 treatment setting for clients, while another 47% of the programs offered 2 treatment settings and 6% of programs provided 3 treatment settings.

Figure 1: Number of Treatment Settings per Program




**Treatment location.** Results revealed that a majority of addiction programs in the study were located in the community, followed by community offsite hospital programs and programs located in a hospital. A total of 11 out of 15 programs (73%) were located in the community, while 3 programs (20%) were located in the community but identified as offsite hospital programs, and 1 program (6%) was located in a hospital.

**Program approaches and philosophies.** As described by study participants, Table 5 provides a detailed summary of the approaches and philosophies used by each program in the study. In general, a majority of programs provided assessments, referrals, one-on-one counselling or support and support groups. Motivational interviewing (MI was also identified as a common approach that was used to increase clients' confidence in, and readiness for change. According to Ms. A, they use a lot of motivational strategies "to help people enhance their confidence that they can change, enhance their readiness to change and recognize that change is necessary for them to move forward and make it in life" (manager/administrator, 14 yrs. addiction field).

There are several reasons why MI is a best practice approach for addressing the addiction needs of older adults. First, this treatment approach has been described as meeting the needs of individuals "wherever they are at" in their recovery journey

(Kennedy et al., 1999; SAMHSA, 1998, p.3). Second, the addiction practitioner fosters a personal environment based on trust, respect and acceptance by viewing each individual as capable of making changes to improve their lives (University of Texas [UoT], 2009). Last, MI complements age-specific principles by using the individual's perspective as a "starting point" for change and placing the responsibility for change on the older adult without moralizing, confronting or labeling older adults (Simoni-Wastila & Yang, 2006; Sorocco & Ferrell, 2006; Hansen & Gutheil, 2004; Gordon et al., 2003; Kennedy et al., 1999; SAMHSA, 1998).

In terms of program philosophies, it is worth noting that 6 programs identified an adherence to abstinence-based principles that guided their work with clients; however, a majority of these programs also recognized the need for a continuum of services in Hamilton that could provide abstinence-based and harm reduction services depending on the clients goals and needs. According to Ms. M "even though we are an abstinence-based program, we understand that in addiction there are lapses and relapses and so we work really hard at not appearing punitive and understanding that relapse is part of the [recovery] process" (front-line worker, 23 yrs. addiction field).

**Tailoring services to specific needs.** As demonstrated in Table 5, 8 programs provided addiction-specific services, while the remaining 7 programs offered a combination of services that were mental health and/or addiction-specific. In some cases, the program was primarily funded for mental health services; however, recognized the need for addiction programming and thus supported clients through support groups geared toward concurrent disorders. According to Mr. F,

Table 5: Agency/Program: approaches and philosophies, clients served and tailored services

| **Approaches/Philosophies** | **MH & A or A** | **Sex** | **Older adult age-specific or mixed** | **Tailoring to specific needs** |
|---|---|---|---|---|
| *Approach:* connect people to services, provide support via telephone and mobile visits, assessment, referral.<br>*Philosophy:* "when in doubt – we go out". | MH & A | Male & Female | Mixed | No wait period, home visits within 24 hours, 24/7 telephone crisis support, partner and have strong relationships with other agencies. |
| *Approach:* One-on-one support, referral, peer support, group support.<br>*Philosophy:* person-directed care/support, recovery-oriented, promote choice and active involvement in treatment, psychosocial rehabilitation. | MH & A | Male & Female | Mixed | Address concurrent disorders, wheelchair accessible.<br>"The individual really drives what we do". |
| *Approach:* screening withdrawal, pre-treatment, support groups, aftercare, teach strategies to manage recovery, peer support, psycho-educational and psycho-therapeutic information for clients & family, case management, housing support, diabetes support, life skills (cooking) shame, assessment, one-on-one counseling, social groups, referrals, preventative, stages of change, crisis telephone support.<br>*Philosophy*: recovery-oriented, value self-help, abstinence-based, empathetic and caring, client-centered, humanistic, empowerment, relational theory, culturally sensitive. | A | Female | Mixed | Language/translation capabilities, support LGBTQ culture, accommodate different needs by providing aftercare and pre-treatment in morning and night. Pre-treatment has no time limit, offer education and support for family members, provide support for concurrent disorders, host self-help groups in-house for clients to attend, provide tours to increase comfort prior to entering program, 24/7 crisis line to address special needs/questions from community members, short waiting period, accommodate preference for outpatient or inpatient care, address medical concerns, address concurrent disorders, partnerships and referrals to other agencies, wheelchair accessible, provide supportive housing. |
| *Approach:* Relapse prevention, stabilize intoxication/withdrawal, assessment, referral, practical management of symptoms, counseling, MI, CBT, DBT, relational theories, increase confidence that change is possible, grounding principles, rational emotive therapy, mindfulness, trauma support, peer involvement, 24/7 crisis telephone lines for family and clients, diabetes support, social support.<br>*Philosophy*: value self-help, evidence informed, best practices, trauma-informed, Maslow's hierarchy of needs, client-centred approach, abstinence-based. | A | Male | Mixed<br>16 + years | Support LGBTQ culture, provide relapse prevention, language/translation capabilities, offer outpatient day programming to community members waiting for treatment "it's a bridge between now and further help," provide family support, 24/7 crisis line to address special needs/questions from community members, peers sharing positive recovery experiences, wheelchair accessible, partnerships and referrals to other agencies. |
| *Approach:* Psycho-educational group support, screening, assessment, case management, one-to-one counseling, referral.<br>*Philosophy:* harm reduction, client-centered. | MH & A | Male & Female | Mixed | Address concurrent disorders, tailor support based on different literacy backgrounds. |
| *Approach:* Psycho-educational groups, one-on-one counseling, CBT, aftercare, family supports.<br>*Philosophy:* abstinence-based, raising the quality of life. | A | Male | Mixed<br>19+ years | Address concurrent disorders, provide supportive housing, address social determinants of health (housing, employment, family), translate materials, provide support for literacy concerns, provide family supports, flexible to increase length of stay if necessary, can adapt program based on cognitive and physical abilities, provide access to ongoing individual counseling, partnerships and referrals to other agencies. |
| *Approach:* MI, group sessions, one-to-one counseling for clients | A | Male | Mixed | Provide palliative support, closely monitor medical concerns, provide |

| | | | | |
|---|---|---|---|---|
| with suicidal ideation, life skills, palliative support, CBT, DBT, psycho-educational, case management.<br>*Philosophy:* Harm reduction, client centered. | | | 22 + years | assistance with housing, accept continued use of alcohol in a safe and monitored environment, language capabilities. |
| *Approach:* needs assessment, referral, one-on-one ongoing counseling, psycho-educational information packages, CBT, social activities, peer support, mobile, case management, building relationships, establishing connections to eliminate barriers.<br>*Philosophy:* Harm reduction, housing first, holistic, recovery-oriented, client-centered. | A | Male & female | Mixed<br>22 + years | Provide mobile support, peer focused, language/ translation capabilities, ongoing long-term support, provide social activities, assist people to prepare for treatment, provide transportation/accompany people to doctor's appointments/exercise/meetings, eliminate treatment barriers (smoke-free treatment centre = help them quit smoking).<br>"We are just really adaptable and were really about meeting people where they are at". |
| *Approach:* Assessment, referral, one-on-one counseling/therapy, psycho-educational group, group therapy, relapse prevention, intake and information services.<br>*Philosophy:* harm reduction. | A | Male & Female | Age-specific<br>55 + years | Age-specific assessment (GMAST) and ongoing gender-specific support groups, age-specific education group, address hearing and vision impairments by providing individualized orientation, wheel-chair accessible, specialized geriatric addiction worker (trained to identify symptoms related to aging, risks or concerns tied to aging and addiction), outreach when clients have health concerns, partner with other agencies, offer wellness workshops in family health clinics, provide an opportunity for supportive social interaction with peers. |
| *Approach:* Life skills and psycho-educational groups and one-on-one counseling, referral, case management, advocate culturally sensitive care.<br>*Philosophy:* cultural sensitivity, holistic care, harm reduction. | MH & A | Male & Female | Mixed | Gender-specific and culturally specific groups and programming, conduct security checks, offer light/moderate house keeping, home visits, and assist with transportation to doctor's appointments.<br>"We assist anyone who walks through the door". |
| *Approach:* Peer support (one-on-one or group), social activities, training, make resources available (i.e. computer, phone).<br>*Philosophy:* – empower, encourage and enable, give people power back. | MH & A | Male & Female | Mixed | Peer environment, ongoing support, can make referrals, no waiting list and no appointments for support, social activities with peers. |
| *Approach:* Pre-treatment, psychosocial support and spirituality, MI, psycho-educational/reflective.<br>*Philosophy:* abstinence-based. | A | Male | Mixed | Provide support for men who are waiting for treatment. |
| *Approach:* Basic life skills training, core-education about addiction, prepare to return to community, referral, support groups and one-on-one counseling, case management.<br>*Philosophy:* abstinence-based. | MH & A | Male | Mixed | Address concurrent disorders. |
| *Approach:* Group support, aftercare, family group.<br>*Philosophy:* abstinence-based. | A | Male | Mixed<br>19+ years | Provide support for family members. |
| *Approach:* long-term intensive one-to-one counseling, psycho-educational, case management, referral, and assessment.<br>*Philosophy:* Harm reduction. | MH & A | Male & Female | Mixed<br>16+ years | Address concurrent disorders under one roof, connect people on waiting lists to concurrent support group offered by WPOP & ADGS, long-term ongoing support. |

> We are funded to do mental health services but we have never turned down people who have an addiction…so we have always worked with people who have a concurrent disorder but we wouldn't pick up anybody who was just having an addiction… it has to be a concurrent disorder. (administrator/manager, 30 yrs. mental health and addiction field)

A majority of programs were geared towards services for men and women; however, 6 programs were specifically geared towards a male population while 1 program serviced a female-specific population. Moreover, all but one of the programs were geared toward mixed-age populations, with different ages of service entry for program users ranging from the early 20s to 100 years and over at the time of entry to the program. A lack of age-specific addiction programming for older adults supports previous literature, in that, across the province there are very few addiction programs that gear their services specifically toward older populations even though the literature recognizes age-specific treatment as a best practice treatment approach for older adults (Rothrauff et al., 2011; Oslin et al., 2005; Oslin, 2004; Colleran & Jay, 2002; Health Canada, 2002; SAMHSA, 1998; Kofoed et al., 1987).

Despite a lack of age-specific programming for older adults, a majority of participants stated that they tried to address individual needs to the best that they could while supporting family members and significant others in the treatment process. Several study participants described their programs as offering services at different times in the day to accommodate client preferences for morning, afternoon or evening services, finding creative ways to assist individuals with literacy concerns (i.e. using symbols or pictures), and establishing partnerships with other agencies to address specific concerns tied to dual diagnosis, concurrent disorders, acquired brain injury and physical

impairments. Some programs identified language capabilities, wheelchair access, gender-specific support groups, using resources to accompany clients on appointments and community support groups, and lengthening the duration of treatment programs to accommodate certain needs or "interruptions" in treatment.

All study participants identified an intrinsic philosophy of their program that centered on "meeting individuals where they are at." According to Ms. F, "the individual really drives what we do... every person is different and they have very unique needs… we take this approach with every single person" (manager/administrator, 20 yrs. mental health and addiction field). Moreover, Ms. B stated, "I would start where they are…[treatment is] really individualized to what the person is comfortable with" (front-line worker, 7 yrs. addiction field).

**Characteristics of Older Adult Clients as Perceived by Providers**

This section will present results and a discussion on the basic characteristics of older adults with substance use concerns accessing addiction services from the perspective of service providers. Characteristics observed included: the most common type of substance abused by older adults, familial ties, socioeconomic status, housing and living arrangements, ethnicity/culture, sex and age, concurrent disorders, criminal justice system involvement and medical concerns.

To begin, alcohol was identified as the most common substance abused by older adults using Hamilton addiction services. While a few study participants identified that alcohol abuse was declining due to the emergence of new substances, such as prescription medication and the increasing availability of illegal substances, they nevertheless

recognized alcohol as the most common substance used by aging individuals. This supports research findings from Andrews (2008), CAMH (2008) and the Public Health Agency of Canada (2010), which reported that between 6-10% of individuals 65 years and older struggle with alcohol problems, and 86.5% of older adults who access addiction services in the HNHB LHIN do so to address an addiction to alcohol.

Several study participants identified a growing number of older adults struggling with polysubstances in addition to alcohol use. An addiction to prescription medication was viewed as the second most common substance abused and often a secondary substance used with alcohol. According to Ms. A,

> "Nowadays polysubstance use is an expected issue rather than an exception. Before it would be alcohol and only alcohol but nowadays we see people over-medicating themselves on minor tranquilizers or opioid substances or narcotics… we also see more older adults coming here with not just one addiction to alcohol, it's often alcohol and then benzodiazepines for example. (manager/administrator, 14 yrs. addiction field).

Moreover, study participants cited a lack of knowledge regarding the impact of prescribed medication on an aging body among medical professionals as a precipitating factor that led to addiction for many older adults. These findings are supported in the literature. According to Health Canada (2002) 20 out of 28 key experts attributed problematic prescription use as a consequence of physicians overprescribing medications for older adults, thus demonstrating widespread recognition of this serious issue.

Service providers identified crack cocaine and marijuana as secondary substances on the rise among older adults. While participants noted that illegal substance abuse was not common, particularly as the primary source of addiction, it was perceived as an

increasingly prominent secondary substance abused among aging baby boomers. This finding is supported by previous literature, which cites the high use of psychoactive substances among the baby boom cohort in the 1960s and 70s as a contributing factor to increasing rates of use among middle-aged and older adults (Wu & Blazer, 2011; Roe et al., 2010; Wu & Blazer, 2009a; Andrews, 2008; Crome & Bloor, 2005a). According to previous research and findings from this study, it is a real possibility that service providers will continue to see an increase in illegal substance abuse among older adults as baby boomers continue to age. These findings further highlight the need for future research on the economic, social and cultural impact of increased use of illegal substances among older adults on society as well as perceptions of growing older.

In terms of familial ties, a majority of study participants described familial relationships as existing on a continuum that ranged from completely absent or "chronically disconnected" to very strong and supportive relationships with family members. Participants reported that it was not uncommon for older adults to be detached from family members, particularly individuals with early onset substance abuse concerns. Moreover, several participants established a connection between detached familial ties and the natural process of aging, wherein family members had passed away or were dealing with their own health concerns. This finding highlights the complexity of older adults social resources as they age, particularly when compared to younger adults, since they are more likely to have fewer sources of support due to long-term substance use. In cases where family members were connected with older adults, study participants

identified that it was often grown children that supported and encouraged their aging parents to seek addiction treatment.

Similar to data on familial ties, the socio-economic status and housing/living arrangements of older adults were described as existing on a “spectrum of economic status” that ranged from impoverishment to affluence and homelessness to home ownership. According to Mr. T, “there is this whole spectrum of drinking; from people who are homeless and living on the street to someone who could be an executive of a company and still be inebriated and having difficulty coping” (manager/administrator, 43 yrs. mental health and addiction field). Older adults were described as ranging from having no fixed address, living on the street, completely on their own and devoid of social support and resources to having close relationships with family members who provided informal support, being financially stable and remaining in their own place of residence.

In terms of ethnicity and culture, it is important to note that of the 15 Hamilton programs involved in the study, one program was geared towards a specific ethno-cultural population. Of the 14 remaining programs, all participants identified that most clients were of Caucasian decent. While some programs saw diversity in some of the older clients, it was recognized across all participants that clients served were not reflective of Hamilton’s diverse population. A lack of cultural sensitivity in addiction organizations may be due to a lack of training opportunities that focus on building cultural sensitivity within the workplace, limited funding/resources for agencies to hire new employees from different cultures (perhaps due in part to job candidates with limited expertise in different cultures and/or addiction care), and in some cases weak partnerships with cultural

organizations that translate into few referrals due to distrust of addiction services or a general lack of awareness that services exist.

With respect to sex and age, participants identified males as higher users of addiction services when compared to females. Of the 15 programs, 6 were geared specifically for men, 1 was geared specifically for women and the remaining 8 were geared toward male and female populations. In terms of age, while 14 of the 15 programs were geared toward mixed-age populations, almost a third of mixed-age programs revealed that the majority of clients were above the age of 50. According to Ms. L, "over 50 is generally who we cater to…we are not trying to become age-specific, it is just kind of how it worked out" (manager/administrator, 6 yrs. addiction field). This finding demonstrates that addiction programs are seeing an increasing number of older adults access their services, which not only highlights the need for increased awareness of strategies for addressing their unique needs but it also underlines the fact that addiction is a growing concern among older adults.

Study participants identified concurrent mental health issues as a common experience among older adults with addiction concerns. Representatives from the age-specific program stated that 60-70% of the people walking through their door had concurrent disorders. The most common mental illnesses identified by participants were depression and anxiety, followed by a history of trauma and bipolar disorder.

A majority of study participants described criminal justice system involvement as not uncommon among older adults. In some cases, crimes involving theft were viewed as desperate acts to survive due to the harsh realities of long-term substance abuse. This

finding highlighted the seriousness of addiction and the potential for experiencing devastating living conditions in old age that stem from hidden, neglected or stigmatized substance abuse concerns and limited access to treatment.

Findings from this study supports research on early and late-onset addiction. More specifically, these findings confirm research by Flood and Buckwalter (2009), Wu and Blazer (2011) and Brown (1982), in that service providers perceived older adults with early-onset addiction to be more likely to have smaller social networks, a history of trauma, “damaged” relationships with family members, lower socio-economic status, more medical complications and a history of drug use. Individuals with late-onset addiction were more likely to have strong family supports, be using substance as a result of difficult life transitions, such as death, loneliness or retirement, and more likely to be socio-economically stable compared to those with early onset addiction.

In regards to medical concerns, many participants described clients aged 50 years and older as “complex” cases with several medical concerns. Ms. D stated,

> So our experience is that clinically [older adults] are a more complicated profile, especially if they have been using for a long time because now their skin looks older, their organs appear older, they look older than they are and their teeth are in a place where they’re not staying in their body any longer. (manager/ administrator, 12 yrs. addiction field)

Interestingly, study participants established a distinction between chronological and biological age by noting that older adults, especially those with long-term substance use, looked older than their years and exhibited many medical characteristics that were not age-appropriate. According to Mr. D, older adults “will be exhibiting many medical characteristics that would not be age appropriate, that would be held by people who were

10 or 20 years older than themselves" (manager/administrator, 30 yrs. addiction field). The relationship between substance use and increased biological age have been explored by different scholars, including research by Carlen et al. (1994), which reported that older adults with alcohol-related dementias were on average 10 years younger than others who were diagnosed with non-alcohol related dementias, thus demonstrating the negative impact of substance use on life expectancy and wellbeing in old age. This finding also supports literature on the life course perspective, which views chronological age as one of several factors involved in the timing of people's lives (Hutchison, 2007). Some scholars have explored the intricate relationship between addiction and aging using the life course perspective and have acknowledged the life course perspective as a useful framework for classifying substance use trajectories, and identifying critical factors, events and relationships that contribute to persistent use or changes in use (Hser, Longshore & Anglin, 2007).

Study participants also identified several medical concerns that older adults present with when they access their services. All participants identified mobility issues and arthritis pain as major medical concerns for older adults. Other common medical concerns included chronic illnesses such as heart conditions, high blood pressure, breathing and lung concerns, diabetes, early signs of cognitive deficits such as Alzheimer's disease or Korsakoff's disease, liver disease and cancer. These findings are supported by research conducted by Coulton (2009), CAMH (2011) and Cummings et al., (2008), which explore the impact of the hazardous use of alcohol, drugs, OTC and/or prescription medication among older adults. These scholars recognize problematic use as

leading to a wide range of physical and psychological problems, including, but not limited to, injury from falls, mobility concerns, liver disease, heart problems and cancer.

A few study participants identified that individuals aged 50 years and older were often unaware of their medical concerns until they sought help and became sober or learned how to better manage their substance use. According to Ms. M,

> The interesting thing for women that I've heard over and over and over again is 'I stopped using my substance and found out that I was sick.' So they didn't know that they had these health problems that were masked by their substance use and it takes a while to convince them… that being clean and sober didn't cause them to be unhealthy… they were unhealthy but they didn't know it because they were using substances and not focused on their health. (front-line worker, 23 yrs. addiction field)

The perception that many older adults discovered that they were chronically or fatally ill *after* they recovered or had learned how to better manage their substance use was another interesting, yet unfortunate finding, that is not commonly referenced in the literature from a social perspective. This finding points toward the need for more research on lived experience in order to explore the social and personal consequences of discovering illness (related or unrelated to addiction) following recovery from long-term substance abuse.

**The unique needs of older adults.** Study participants identified several differences between the needs of older and younger adults in addiction treatment programs. First, a majority of participants acknowledged that older adults were more likely to have complex health and medical needs when compared to younger adults. According to Ms. X, "I think health is probably one of the biggest [differences]…they are starting to experience different health issues than people that might be in their 30's" (manager/administrator, 16 yrs. addiction field). Moreover, Ms. L stated that "younger

adults haven't yet reached that point where their liver has said 'hey, you can't do that anymore', whereas a lot of older guys have had their liver telling them, 'no, I am not doing this anymore'" (manager/administrator, 6 yrs. addiction field).

This finding is supported by existing research that explores the impact of prolonged and/or heavy use of substances on the physical and psychological wellbeing of older adults. According to Scott (2008) substance abuse can cause or exasperate physical and psychological conditions associated with aging. For this reason, older adults are more likely to present with complex medical and health needs when compared to younger adults. It is imperative to address substance abuse and complex medical and health care needs simultaneously in order to enhance treatment adherence and the client's experience. In order to address this issue, treatment services must ensure sufficient time and program flexibility as well as provide access to medical expertise throughout the duration of the program.

Second, study participants identified that treatment needs were different between younger and older clients because of their different life stages and experiences. Not only were older adults described as suffering from complex health and medical concerns but they also had different life experiences and were in different life stages when compared to their younger counterparts. For example, older adults were more likely to be struggling with the death of friends or close relatives, changes associated with retirement and/or social isolation, and younger clients were often concerned with parenting and work-related issues. According to Ms. B,

If [older adults] go to a treatment agency or a residential program and everyone

> else there is younger and dealing with childcare, child custody, work life – all those things that are a different time in your life – they feel separate from that and they feel not listened to and not as comfortable…[they are looking for] information about how you manage your retirement, how you schedule your time, whether you get more involved in volunteer work and how you build structure, which would be very different if you were still working and balancing other obligations. (Front-line worker, 7 yrs. addiction field)

Third, study participants identified that older adults were more likely to be isolated, reserved and less “demanding” for services when compared to younger adults. According to participants, these characteristics made it necessary for agencies to give older adults the opportunity to socialize and build support relationships with older peers in recovery. According to Ms. X,

> There is the need to connect with others, I think that is why support groups are good for people because we tend to get some older adults who might be a bit isolated, so it’s a safe way to sort of get supports and social interaction, and from there we can hopefully help people connect with different programs in the community. (manager/administrator, 16 yrs. addiction field)

These finding confirm previous literature on different life stages, experiences and personalities of younger and older clients (Rothrauff et al., 2011; Colleran & Jay, 2002; SAMHSA, 1998). It furthermore, supports the need for access to age-specific treatment for older adults to ensure that treatment information and programming is focused on issues relevant to aging individuals and to reduce isolation by increasing opportunities for social interaction with peers from their age cohort.

Last, study participants described older adults as showing a greater readiness for change and a stronger commitment to their treatment plan when compared to younger adults, regardless of whether they were enrolled in an age-specific or mixed-age treatment program. Their readiness and commitment was seen as being tied to their need to be an

active participant in their care plan. According to Ms. J, "by the time they are older and come here I think they are ready and more committed in the progress of their recovery" (manager/ administrator, 7 yrs. addiction field). Moreover, Ms. L stated that for

> the younger adults it seems to be that there has to be a lot more shades of grey [in their care plan] where with the older adults, [their care plans] seem to work better for them when they are involved in the process… if it's written down and they've signed off on it then that's how it is going to be. It's just one of those old school values where it's like if I give you my word that means I am not going to [drink]. (manager/administrator, 6 yrs. addiction field)

This finding adds to the literature, in that, previous research has highlighted an increased commitment to treatment among older adults as a direct outcome of access to age-specific care; however, this finding suggests that even in mixed-age treatment programs, which do not offer age-appropriate psychotherapeutic strategies, older adults show greater motivation for change than younger clients. This not only supports previous literature, which suggests that older adults have a higher likelihood of recovering in an age-specific environment but it also highlights stronger motivations for change among older adults who seek treatment (Rothrauff et al., 2011; Oslin et al., 2005; Colleran & Jay, 2002; SAMHSA, 1998; Kofoed et al., 1987). Additional research should seek to gain a better understanding of older adults' greater motivations for change that lead to their decision to seek treatment in order to help services reach out and motivate other older adults that have addiction concerns but are more hesitant to seek help and remain hidden in the community.

## Barriers to Addiction Services

Study participants identified several barriers that older adults experience when they are in need of addiction services. The barriers to addiction services were organized into 5 themes: cultural barriers, stigma, psychological barriers, knowledge barriers and structural and program barriers. This section will report on data gathered from study participants in each of the 5 themes and will discuss findings in light of existing literature.

**Cultural barriers.** Study participants described cultural barriers as stemming from a lack of language capacity in agencies/organizations and expensive translation services. Study participants also identified a lack of knowledge regarding the "intricacies of different cultures" in treatment programs.

***Language barriers.*** Study participants reported that few agencies/organizations provided multi-lingual services. This was seen as a significant barrier for older adults that had little to no English capability. According to Ms. K, "if you look at it, people really need to understand English in order to come to a service such as ours…" (front-line worker, 38 yrs. mental health and addiction field). Ms. K provided an example of a Spanish-speaking client that spoke broken English; she was concerned about this language barrier because she "was never sure if he was getting absolutely everything" that they discussed. "So you know, maybe there are lots more people out there that we are not aware of and they won't come forward because their English is poor" (Ms. K, front-line worker, 38 yrs. mental health and addiction field). Moreover, Ms. A stated,

> I have a few clients who don't speak English and there's not even one [addiction] service in Hamilton and Burlington that offers services in Russian and Polish. I have talked to a doctor from the Shelter Health Network, and she said she sees

> [non-English speaking clients] all the time and *they* don't even have the ability to communicate with them. So I think the system needs to improve in terms of language. (manager/ administrator, 14 yrs. addiction field)

Language barriers were seen as impacting not only whether or not older adults accessed addiction services but also their knowledge that services existed in Hamilton. According to Ms. A., "they don't know the system, they know it even less than everybody else… they might be computer savvy but if they cannot read what is in front of them then it's useless" (manager/administrator, 14 yrs. addiction field). Furthermore, several study participants identified language barriers as an outcome that was tied to a lack of affordable translation services. According to Ms. R, "it's hard to get a translator and it's very costly as well" (manager/administrator, 17 yrs. addiction field).

***Lack of knowledge regarding different cultural norms.*** Study participants recognized a general lack of awareness of the cultural practices and norms of clients from foreign countries among addiction service providers. Cultural norms and practices included the decision of whether to avoid or maintain eye contact with clients as well as the need to connect clients with service providers that shared the same gender. Study participants perceived these barriers as impacting whether or not clients sought addiction treatment, and in cases where clients accessed addiction treatment, a lack of awareness regarding cultural norms were perceived by study participants as reducing the clients overall satisfaction and comfort. According to Ms. A,

> Canada, being such a cultural mosaic, I think is not very well equipped to deal with the influx of immigrants that they have allowed to stay here. I have one Muslim team member and he has opened my eyes to so many things I wouldn't even pay attention to like when to maintain eye contact and when not to. For some [clients] it may be offensive or unacceptable to deal with women and when people

> go to the hospital and are admitted, most nurses are women, so they may not access services for that reason… Not every client has the ability or attitude that will allow them to challenge us because they come here in a vulnerable state and they think maybe it's not their place for them to tell us because it's rude. (manager/administrator, 14 yrs. addiction field)

Ms. A eloquently demonstrates the complexity of training cultural sensitivity among service providers, since many clients may be reluctant to express their concerns, needs and preferences out of fear that it is inappropriate to request culturally-specific care.

A lack of multi-lingual, culturally sensitive services create a significant barrier for older adults from diverse ethnicities and negatively impact not only their decision to access addiction services but also their knowledge that services exist. Research on addiction is scarce in terms of older adults from diverse ethnicities. Andrews (2008) explored the perspectives of key experts in the U.S. regarding the needs of older adults from Latino communities. She reported that Latinos experience multiple barriers to identification and assessment of substance abuse. Language barriers and stigma associated with use of mental health and addiction services were identified as two of the main obstacles experienced by older adults (Andrews, 2008).

Andrews' (2008) research on the barriers that Latino seniors encounter is applicable to the experiences of other older adults from different ethnicities. Andrews' findings also relate to existing literature on immigrants and their patterns of use when it comes to addiction and mental health services. Previous literature suggests that immigrants are less likely to seek services for mental health and addiction issues due to a general lack of awareness of community services, language and communication barriers, fear of stigma within families and communities, systematic and individual discrimination

and mistrust of mental health and addiction services (CAMH, 2009; Agic & Scheffer, 2003; Johnson & Carroll, 1995; USDHHS, 2001). Thus, findings from this research study add to existing addiction literature on older adults from diverse communities by reporting on several cultural barriers that obstruct older adults from seeking help in Hamilton, Ontario. In order to effectively address emerging diversity trends in Hamilton, this study points toward the need for more research on cultural sensitivity and accessibility in addiction services.

**Stigma.** Study participants described stigma as a prominent issue that contributed to the following psychological barriers for older adults: fear of change, acceptance of addiction and decision to seek help. Older adults were described by study participants as being exposed to systematic stigma and discrimination that often led to the internalization of stigma and manifested in their decision to avoid addiction treatment or silence their needs. According to Mr. R,

> The thing about stigma is that it's bigger than having a campaign saying 'old people drink'…the easiest thing would be to put things into place for people to maintain their goals and the hardest thing would be to get them in the door…what's hard is getting them in the door. (manager/administrator, 26 yrs. addiction field)

Moreover, Ms. X stated, "I think there is a stigma within older adults so I am not sure that they would come forward necessarily with information that [substance use] is a problem" (manager/administrator, 16 yrs. addiction field).

A majority of participants identified a connection between stigma, shame and generational norms and expectations. According to study participants, systematic stigma and discrimination, which is often instigated by generational or religious norms and

expectations, led to the internalization of stigma in older adults and resulted in fewer people seeking help. Older generations were described as growing up in an era where people were expected to take care of themselves and avoid all association with mental health and addiction professionals in order to avoid being labeled as a "crazy" person. According to Ms. A,

> We are talking about two generations back. For example, addiction to alcohol was something that was looked at differently and people were told to keep their problems to themselves and not necessarily 'air their dirty laundry' so that might be another difficulty for them to even make [their addiction] known. (manager/ administration, 14 yrs. addiction field)

On a broader level, study participants identified systematic stigma and its impact on the amount of research geared toward older adults with an addiction. According to Ms. A,

> I think that there is a humongous amount of research on cancer. If you look at the amount of research on addiction it's probably 1/10$^{th}$ of a percent of money that goes towards cancer research. So I think these would be the biggest ones and stigma is probably the reason why people don't want to invest [in research on addiction]…". (manager/administrator, 14 yrs. addiction field)

Service providers also described systematic stigma and discrimination as relating to the common misconception that people *choose* to become addicted to substances. According to Ms. A,

> I don't know one person who chose [addiction] for themselves…you know they [don't] say, 'I'm 18, it's time to put something on my resume; I want to put that I am a crack-cocaine addict because it looks great, right?' I think once people realize that the old-fashioned thinking about [addiction] - that it's willpower or it's a moral issue - once they realize it's a legitimate concern that needs to be treated and can be treated successfully I think then people will be much more open to be supportive in so many ways…". (manager/administrator, 14 yrs. addiction field)

These findings demonstrate the potentially devastating impact of internalized stigma on one's decision to seek professional help. Individuals that decide to avoid professional help and conceal their substance use concerns due to fear of stigma run the risk of remaining undiagnosed (CAMH, 2008; Health Canada, 2002; Coogle et al., 2000). Continued, long-term undiagnosed misuse of substances will not only negatively impact existing relationships with family and friends, which may lead to isolation but it will also result in a loss of autonomy, reduced life expectancy and morbidity, which will result in a greater demand for expensive healthcare services and constrain the effectiveness of treatment and rehabilitation programs. For this reason, it is imperative that research be conducted on effective strategies for reducing stigma associated with addiction among the elderly population.

Fortunately, research is available on reducing social, structural, and self-stigma related to addiction for mixed age populations. For example, Livingston, Milne, Fang and Amari (2012) provided a systematic review of interventions for reducing stigma related to substance abuse and reported that social stigma can be addressed by MI and sharing stories that highlight positive messages of people with lived experience of addiction. Structural stigma can be reduced by providing educational programs for medical students and allied professionals (counselors, police officers) as well as contact-based training wherein interaction is facilitated between the public and people with lived experience of addiction (Livingston et al., 2012). Lastly, therapeutic interventions, such as group-based acceptance and commitment therapy, can effectively reduce self-stigma (Livingston et al., 2012). While exposure to stigma and discrimination are common among all individuals

with lived experience of substance abuse, it is important to note that older adults are also subject to additional stigma that views them as “invisible,” “worthless” or a “drain on society” (CAMH, 2008, p.8). Thus, previous research should serve as the basis for additional research that is geared specifically toward the effectiveness of interventions that reduce stigma against older adults that live with an addiction.

**Psychological barriers.** All study participants acknowledged psychological barriers as a significant issue for older adults that greatly impeded their ability and/or decision to access addiction services. Psychological barriers were loosely categorized into two subthemes: fear of change and seeking help, and fear of shame. Several study participants described sub-themes as intricately connected and dependent upon one another, and furthermore suggested that stigma and shame contributed to psychological barriers. According to Ms. G, “I think there is a multitude of barriers…they all feed into one another, which is why I think it is difficult because there are all different reasons” (manager/administrator, 8 yrs. addiction field).

***Fear of change and seeking help.*** Several study participants described the decision to access treatment as a fearful and often anxiety-provoking event for older adults, since it signaled the need for change, the need to give up something that they found important, and something that shaped their social lives and interactions. Ms. M stated that many older women ask addiction workers,

> Like ‘what’s ahead for me?…[substance use has] been my life for a long period of time… how do I do it differently?...All my friends use, what am I going to do? Here I am 55 or 60 years old, how do you meet new people at my age? My whole social life has been around my relationship with my bottle or my pills and now what do I do because I don’t know anybody that doesn’t drink?’ We hear those

things all the time. (front-line worker, 23 yrs. addiction field)

A majority of study participants highlighted that older adults were reluctant to change as a result of their perception that they simply could not change because they were "too old to get better" or substance use was perceived as their one true pleasure in a long and hard life. According to Ms. A, "I think they lose hope and confidence that they can get better" and "if they are really old they may just not want to address it because it's something for them to hold onto" (manager/administrator, 12 yrs. addiction field).

According to study participants, fear of change was also related to the fear of accepting the existence of a problem, the need for help and the need to acknowledge a loss of control regarding the management of substances. According to Ms. B,

> I think facing the problem is the first barrier because particularly when you're older the historical pieces around negative stigma are there right… so just facing the fact that there is a problem, and deciding to do something about it, I think is harder for [the older] population. (front-line worker, 7 yrs. addiction field)

When speaking about older adults' fear of acknowledging addiction, Ms. J stated, "we don't want people to know we are hurting, we don't want people to know what is going on with us. We try to hide things and isolate ourselves as we grow older" (manager/administrator, 7 yrs. addiction field).

Several study participants identified that some older adults were fearful of seeking help due to concerns regarding the potential loss of autonomy and independence, as well as a loss of privacy and concern for pets. In terms of a loss of autonomy and independence, older adults were seen as being fearful of leaving their homes and becoming dependent on services. For example, Ms. A stated, "they usually experience a

lot of fear around leaving their own home and place of residence to stay somewhere else… so breaking this internal barrier may be very difficult" (manager/administrator, 14 yrs. addiction field).

With respect to the potential loss of privacy, one study participant in particular stressed the importance of maintaining privacy among older adults in treatment. According to Ms. A,

> We know that everybody likes privacy but seniors, definitely…We know people, once they enter their 70s or 80s are naturally a little bit more paranoid, so they probably worry that people tell others "oh he's an alcoholic" or "he's using drugs" so that's another barrier. I think if we were a little bit more private we could reduce that barrier. (manager/administrator, 14 yrs. addiction field)

Moreover, it was perceived that older adults with pets found it more difficult to seek assistance for addiction needs, since they could potentially lose their pets or be forced to leave them behind. According to Ms. W,

> I find that the older the person the harder it is for them to get motivated and to get out of their place and to leave things behind… yeah, I mean it's the pets too… a lot of them have cats or a dog or something and they don't want to leave them behind. (front-line worker, 12 yrs. addiction field)

***Shame.*** A majority of participants described feelings of shame among older adults as stemming from norms and expectations that viewed substance use in a negative light. These norms and expectations were either religious in nature, for example seeing substance use as a sin or a taboo practice, or they were generational, for example older adults would think "I'm older, I should know better". Shame was also identified as resulting from the belief that they had let down their families and loved ones.

When comparing older adults with younger adults, service providers argued that shame tended to be cumulative for older adults and thus a greater concern and barrier for accessing services. Participants suggested that individuals with early-onset addiction faced long-term shame that amplified issues in old age and produced greater psychological barriers, inevitably impacting their decision to seek help. One study participant noted,

> I think shame is cumulative… that the shame that I feel at 20 is even worse by the time I am 40 and is even worse by the time I'm 60…especially if I haven't done anything about it...I think exponentially it gets bigger. So some of the things that are issues at 20 or 30 I think are just bigger as you age… that's just my thoughts. (Ms. D, manager/ administrator, 12 yrs. addiction field).

The finding that cumulative shame is an outcome of unresolved early life experiences warrants acknowledgment of the life course perspective, particularly the linkages between life events and transitions that take place in childhood, adolescence, adulthood and late adulthood (Hutchison, 2007). Several life course scholars have drawn attention to the impact of "cumulative disadvantage" and "cumulative advantage", both sociological concepts, to explain inequalities within cohorts and the impact of negative early life events on late life experiences (Hutchison, 2007, p.30). In accordance with the life course perspective, Hutchison (2007) reported that disadvantaged childhood events, such as experiences of trauma, shame, or parental substance use, shaped the lives of individuals decades later, and led to greater disadvantage when early traumas were not resolved through intervention.

Hence, the current research study is congruent with previous literature on the impact of life events across the life course. It furthermore, points toward the need for

greater intervention in early stages of life in order to reduce the economic, social and personal impact of long-term issues, which may be a contributing factor to substance abuse in old age as a coping mechanism for addressing unresolved pain or shame. A review of the literature also highlights a lack of research on the impact of long-term shame on older individuals with substance use concerns; thus, pointing toward the need for additional research that explores solutions to the intricate relationship between addiction and shame among older adults.

**Knowledge barriers.** Study participants identified a lack of knowledge among service providers and/or older adults as major barriers to service. More specifically, study participants identified 3 knowledge barriers: (a) older adults lacking knowledge of addiction services, (b) a lack of system knowledge regarding available addiction services among addiction and non-addiction organizations and/or employees, and (c) organizations and/or workers lacking knowledge on the needs of older adults with addiction concerns.

***Older adults lacking knowledge of addiction services.*** Several study participants highlighted a lack of knowledge regarding addiction services among older adults as a barrier to accessing help. A lack of knowledge stemmed from isolation, a lack of public education on addiction, a lack of service collaboration, confusion regarding the addiction system and a lack of familiarity with electronic search engines that offered the opportunity to learn about services. According to Ms. A,

> They might have limited access to information and often they are either scared or too embarrassed to ask so they are not likely to be able to look us up and know that we are a free service… they might not even have access to our number because they simply wouldn't know how to find us or they wouldn't simply know that we exist. While you know any 16-year-old will go to the computer and will

> Google ‘addiction help in Hamilton’ and find us right away. (manager/administrator, 14 yrs. addiction field)

This finding complements research conducted by Health Canada (2002) and PSSS (2004). Health Canada (2002) argues that older adults have limited awareness of the availability of addiction programs and highlights the need for increased awareness and education opportunities for older adults that focus on seniors rather than provide generic information for all adults. Moreover, PSSS (2004) reported on focus groups held with older adults in recovery and found that older adults strongly expressed feelings of wanting to be better informed and viewed as active participants in treatment planning initiatives. Older adults noted that it was important that services providers not allow individuals to become lost in the system as a result of limited knowledge of available services; and furthermore, stressed a need to explore opportunities for increasing awareness of the issues pertaining to substance misuse among older adults, service providers and the general public.

***A lack of system knowledge.*** A majority of study participants perceived a lack of knowledge regarding available addiction and/or older adult services among providers. According to Ms. A,

> It happens that some of the hospital departments, our own hospital departments, don’t know about us. I call security and they will say, ‘where are you from? I’ve never heard of it.’ So how would somebody at home who is maybe drinking every night, doesn’t watch TV or maybe doesn’t even know what is going on know about this place? (manager/administrator, 14 yrs. addiction field)

A lack of system knowledge among health and social service sector providers was perceived to lead to improper referrals, duplicate services offered by different programs

across the city, and reduced access to programs. According to Ms. A, "I don't even think physicians working at emergency departments know what [we are] about. So they either don't utilize us at all or they don't utilize us properly…" (manager/administration, 14 yrs. addiction field). Moreover, Ms. X argued,

> It's the coordination and knowing who is doing what that I think is always a bit of a challenge. So there are probably new programs out there that we don't know about that you know our clients could probably access. I think it's just how – because in some ways you don't want programs that do it all because then you end up repeating yourself… but I think at the same time when you have programs all over the place then it does take a lot to coordinate at times. (manager/ administrator, 16 yrs. addiction field)

***Service providers lacking knowledge on the needs of older adults with an addiction.*** Another important barrier pertained to a lack of knowledge regarding the needs of older adults among addiction service providers. More specifically, study participants identified a lack of knowledge regarding the characteristics and needs of older adults, strategies for encouraging older adults to seek treatment, the impact of substances on an aging body, and the prevalence and severity of older adults struggling with addiction concerns. According to Ms. D,

> The most pressing concern would be the clinical piece, which is understanding what alcohol and substances do to a body as it ages and providing the right treatment for them… The other key piece would be looking at what works to get them into programming… How do we motivate people to make those changes? How do we assist people to define coping strategies that they never thought of before… so I think there's a lot to learn yet. (manager/administrator, 12 yrs. addiction field)

Some study participants expressed dismay and frustration with not understanding and/or meeting the needs of older adults in their treatment programs. Ms. M stated,

> I believe from talking to staff and being a staff person here that it's also frustrating

> and you feel that you know, 'I'm not really meeting the needs of this woman,' which doesn't help [with job] satisfaction…I think we need more staff training. (front-line worker, 23yrs. addiction field)

Moreover, study participants argued that a lack of knowledge regarding the needs and characteristics of older adults with addiction concerns led to substandard assessment and screening practices, particularly in the social service and aging field. According to Ms. X,

> One of the biggest issues is probably just assessing [older adults]…for people who already work with older adults - how well are they screening? How well do they know what's in the addiction system? …Do we know that everybody out there is asking the questions [on addiction]? (manager/administrator, 16 yrs. addiction field)

Ms. X gave an example by stating,

> I think what happens sometimes is people end up in the hospital and [addiction] is not always caught because at that moment it's about a broken hip or a fall and like you know, was substance use a part of that? (manager/administrator, 16 yrs. addiction field)

These findings highlight a significant gap in knowledge among service providers that work directly with older adults struggling with addiction concerns. While service providers undoubtedly do the best they can to meet the needs of all clients, results from this study demonstrate a lack of knowledge regarding the impact of substances on an aging body, useful strategies for motivating older adults to make changes or seek treatment, effective treatment approaches for older adults and the basic assessment and screening practices for detecting addiction.

Limited knowledge of the needs of older adults among service providers, and restricted knowledge of addiction services among older adults were anticipated by the

literature. Previous research conducted by Schonfeld and colleagues (1994) and PSSS (2004) highlight similar findings. A majority of service providers in both research studies reported little to no training opportunities for learning about the treatment needs of older adults and as a result, revealed diminished confidence when working with older adults to address their treatment needs. These findings point toward the need for greater collaboration and partnerships between and within sectors to increase awareness of existing services for older adults, avoid duplication of services, improper referrals and enhance access to programs that have knowledge on the unique needs of older adults with substance use concerns.

**Structural and program barriers.** Service providers reported that limited knowledge of the unique needs of older adults contributed to structural and program barriers. These included: restricted program capacity to address medical and physical needs, limited resources for simultaneously addressing co-occurring mental health concerns, a lack of age-specific or "age-sensitive" care, limited funding for programs, a lack of aftercare services for older adults, and limited collaboration among service providers within and between health and social service sectors.

***Medical and physical limitations.*** Study participants identified medical and physical limitations as barriers to service for older adults with addiction concerns. Medical barriers included: a lack of knowledge among physician's regarding the special needs of older adults, such as awareness of the process of withdrawal for older adults and the potential for multiple prescriptions leading to dependence. According to Ms. A,

I don't think we use the resources that are out there appropriately… people go for

> a quick temporary Band-Aid, and doctors say 'here take this pill because by the time you see a chronic pain specialist it will be like 3 years and this is just to give you something in the meantime' and that's how they become addicted. (manager/administrator, 14 yrs. addiction field)

Other medical barriers included program or private practice mandates that exclude individuals with complex medical needs due to resource restrictions, and programs without onsite physicians available to address the medical needs of older adults. According to Ms. A, "we had a situation with a client who had a colostomy bag that was denied access to treatment because they thought that his needs would be too high for the level of expertise" (manager/administrator, 14 yrs. addiction field). Moreover, Ms. J argued for the need to increase leniency in programs when it came to allowing clients to consume prescribed medications. She argued that the most pressing barrier for treatment for older adults were limitations regarding medications. She stated, "don't let medication be a barrier to letting someone get help for themselves" (manager/ administrator, 7 yrs. addiction field).

In terms of physical limitations, participants identified older adults as presenting with complex physical concerns, such as mobility and sight impairments. For this reason, study participants described the physical design of programs as essential for accessing services. Many study participants identified that programs lacked wheelchair accessibility, and staff training for safely transferring people to and from their assistive devices. Furthermore, participants emphasized the need for improvement, especially for services to better meet the needs of older adults. According to Ms. B, "I think all treatment should be physically accessible but I realize that's cost and buildings are old

and that kind of thing but I think that that's important" (front-line worker, 7 yrs. addiction field).

A majority of participants identified transportation as a significant barrier for older adults. For older adults paying out of their own pockets, transportation was viewed as costly and at times dangerous during the evening hours. For individuals reliant on government-funded transportation, eligibility standards were unclear and confusing or they were forced to book appointments weeks in advance in order to get transportation.

Many physical and medical limitations identified by participants can be found within the literature (Health Canada, 2002; Lawton Barry, Blow & Oslin, 2009). It is important to note that while these barriers are briefly mentioned in existing literature, there is a paucity of strategies for addressing physical and medical limitations for older adults and many programs find it very difficult to reduce medical limitations due to limited resources. Multidisciplinary research projects should explore strategies for addressing these issues to enhance the older adult's treatment experience.

***Co-occurring mental health concerns.*** Several study participants expressed concern with regards to some services having limited capacity to address the needs of older adults with concurrent addiction and mental health concerns. While many perceived service providers to be aware of the prevalence of concurrent disorders among clients, participants suggested that some services were not very well equipped to address concurrent disorders simultaneously. According to Ms. A,

> Although we fight very strongly against this, we still see that people don't necessarily treat co-occurring disorders together. Often you hear from the mental health field, 'oh, you have to take care of the addiction first before I can diagnose

> them as a psychiatrist.' Sometimes you will see in the addiction field, 'oh you know what, it is his bipolar that is more critical now than his addiction so we need him to be stabilized psychiatrically before he can come to us because he is dangerous when he is in active mania'…so I don't think we are very well-equipped to be able to address those simultaneously. (manager/administrator, 14 yrs. addiction field)

Moreover, the needs of individuals with concurrent disorders were viewed as more complex and thus requiring greater attention from service providers. For example, one participant noted that older adults with concurrent disorders found it difficult to share their stories in group therapy sessions due to a degree of discomfort that they felt by sharing stories with people who did not share their experience. According to Ms. X,

> Some people who have mental health [and addiction] issues have difficulty in groups because they have anxiety and depression and sometimes there is some hesitation to sort of share in groups… A lot of people will say 'I feel much more comfortable knowing that other people in the group have something similar to what I have.' (manager/ administrator, 16 yrs. addiction field)

This quote demonstrates that older adults benefit from feeling a sense of community in treatment, not only with people who are similar in age but also with people who share similar lived experience.

Moreover, study participants noted that effective addiction treatment relied on the program's ability to address co-occurring mental health concerns. According to Ms. J,

> If we determine that they are also struggling with mental health issues than that also becomes an issue that we address because a lot of places are not geared to deal with concurrent. They recognize that [mental illness and addiction] go hand in hand but a lot of places either deal with mental health or addiction. We have to deal with the individual so whatever they come with we have to deal with that package. (manager/administrator, 7 yrs. addiction field)

***A lack of age-specific or age-sensitive care.*** A number of study participants identified concern with regards to a lack of age-specific care for older adults with

addiction. More specifically, study participants recognized two main barriers pertaining to age-specific care: receiving support from young addiction workers and being placed in mixed-age programs with younger people.

*Treatment support from young addiction workers.* Several study participants identified this as a potential barrier for accessing and/or doing well in treatment for older adults. Receiving counselling, therapy and/or education support from younger workers was seen as making some older adults feel uncomfortable or resentful when it came to sharing their stories. Older adults perceived younger workers to have less knowledge and experience when it came to understanding and addressing their needs. According to Ms. K,

> Sometimes there's some resentment if you are a younger worker and they're older, you know, it's kind of like, 'what do you know, I'm in my 60s now, so what do you know? I know far more than you do'. (front-line worker, 38 yrs. mental health and addiction field)

Previous scholars have noted the importance of employing providers that are interested in, and have appropriate training in gerontology and substance abuse (Health Canada, 2002). This research finding contributes to the existing body of literature on older adults and addiction by revealing yet another dimension to the provision of age-specific care. Future research should explore the benefits of assigning older adults with older counsellors to determine the degree to which older workers reduce feelings of resentment and distress, improve treatment completion rates and long-term maintenance of recovery goals. Moreover, research on this topic should focus on the perspectives of older adults in order to assess the true validity of these claims.

*Mixed-age programs.* Study participants identified several issues with regards to mixed-age programs for older adults. In general, participants identified differing lifestyles and life stages between young and older adults that often resulted in adverse treatment experiences for older adults, especially when they were the only individual above the age of 50 in their program.

In terms of differing lifestyles, study participants argued that older adults had different life experiences than younger adults, which made it more difficult, "shocking" or frightening to listen to some of the stories of younger people who were homeless or struggling with an addiction to a "harder" substance. According to Ms. M,

> I've had many women that say 'I can't relate to their life' and often they are shocked by the life of younger women because you know they talk about experiences that come hand-in-hand with the substances that they're using. So you know there are younger women that are involved in using crack… you know the experiences that they do to support their drug habit often shock an older person who didn't have that lifestyle. So they feel separate from them…which is another form of isolation and that is unfortunate. (front-line worker, 23 yrs. addiction field)

Another study participant suggested that listening to the sometimes harsh stories of younger individuals convinced older adults that their substance abuse was not as bad and more acceptable; therefore, potentially impacting their goals. According to Ms. N, my older clients

> would go to the group once and come back saying, 'that's just a group of people who are addicted to crack and I can't relate with that…my addiction is not as bad as that… I am not stealing… my drug is legal. I can go to the liquor store and buy alcohol'. (front-line worker, 6 yrs. mental health and addiction field)

In terms of differing life stages, study participants recognized that at the time of treatment, younger and older adults were experiencing different stages in life, such as

parenting, child care, and employment versus retirement, death, loss and illness. When placed in mixed-age programs with a majority of people below the age of 50, discussion in groups often focused on the issues of younger clients. Study participants believed that this made older adults feel isolated, ignored, disrespected and uncomfortable, thus negatively impacting their treatment experience.

These research findings on older adults' negative experiences in mixed-age programs are well documented within existing literature. Similar findings were reported by Health Canada (2002), Andrews (2008) and PSSS (2004) and research that compare the treatment outcomes of older adults enrolled in age-specific versus mixed-age programs (Oslin et al., 2005; Kofoed et al., 1987; Blow et al., 2000).

A few study participants reported that placing older adults with younger adults in treatment had the potential to deter older adults from focusing on their own needs in treatment; mainly because younger clients placed expectations on older adults and viewed them as naturally more "nurturing" and "mother-like." According to Ms. M,

> Often what happens, and we have to strongly discourage it, is the expectation from the younger women that they put on older women. So they do things like call them mom and you know, they kind of expect that they will get that kind of nurturing from somebody who is older just because they're older… and that's the role that the older woman will take because that's been her role in her life and she sees the younger woman who is struggling or hurt or has been through awful things or having a problem with her family and so she'll take on that role. (front-line worker, 23 yrs. addiction field)

According to Ms. M, this is a negative experience for older women because, "it gets in the way of being seen as an equal in the group… I think that the older women probably would become the listeners for the younger women," therefore, taking away from the

time that they could share their own experiences and focus on their own needs. According to Ms. A, "it might be a positive experience or not because sometimes it really deflects the attention from themselves…they end up helping a younger person versus helping themselves" (manager/administrator, 14 yrs. addiction field).

This finding adds to the existing body of literature by drawing attention to the intergenerational dynamics of clients in addiction programs. In particular, this finding draws attention to the concern that some programs default their services to cater to younger clients and that older adults are subject to inaccurate presumptions that not only deflect attention away from their needs but also forces them to become "listeners" or "parental-figures" rather than equals in treatment. This furthermore supports the need for access to age-specific treatment in order to ensure that older adults receive the care they need to successfully recover.

On the other hand, it is important to note that some study participants viewed the expectations of younger adults as a positive experience for older people, since they were then able to give back in the sense of providing advice, teaching life skills, encouraging younger peers to maintain their recovery goals and become positive figures in the community for their families and children. One study participant noted that this interaction helped older people find their purpose in life. According to Ms. A, "older people sometimes feel like they have found their purpose behind their addiction because they can help someone else, they can take young individuals under their wings" (manager/administrator, 14 yrs. addiction field).

This finding extends existing literature on intergenerational care. There is an abundance of research on the benefits of intergenerational care for seniors and youth (Jarrott & Smith, 2010; Dunham & Casadonte, 2009). Existing research highlights that intergenerational care enhances socialization patterns and reduces isolation for older adults since they are able to feel useful and productive (Holmes, 2009). Furthermore, intergenerational care gives them the opportunity to learn from younger adults or children. It also increases feelings of emotional support, unconditional friendship and acceptance since older adults are given the opportunity to participate in meaningful activities (Holmes, 2009). Intergenerational care increases their self-esteem and helps older adults feel a rejuvenated sense of purpose since they report feeling that they have positively contributed to the development and growth of younger persons (Holmes, 2009). While these findings are not specific to intergenerational care in addiction settings, they nevertheless support the current research study and furthermore point toward the need for future research that explores strategies for balancing preference for age-specific care with opportunities for "giving back" to younger cohorts in a respectful, nonjudgmental environment.

Several study participants highlighted some general practices in mixed-age programs that lacked age-sensitivity, in that they placed expectations on older adults without recognizing their need to feel independent or recognizing them as individuals with wisdom and life experience. For example, one participant identified the use of token treatment, a treatment where clients are given tokens during the week to cash them in for rewards, as potentially making older adults feel as though they are being treated like

children. A few participants mentioned the need to respect the harmless routines of older adults, for example wanting to wake up at 5:00 a.m. to sit quietly and have tea. According to Ms. T,

> For the most part this [older] population, I mean… these are not women that are up at 5 in the morning wreaking havoc, they want to sit quietly and have a tea and for us to honour that is to be respectful of where she is in her life. (manager/ administrator, 16 yrs. addiction field)

Study participants also mentioned the need to provide shorter group sessions, sessions in the evening and morning to be flexible to the schedules and preferences of older adults, and recognized the need to be flexible with "homework assignments" in treatment programs. According to Ms. R, the barriers are "probably our assumptions, our expectations around what type of work they have to be doing like when it comes to homework. I know if I was 70 years old and I was told to do *homework*…(shakes head and laughs)" (manager/ administrator, 17 yrs. addiction field).

***A lack of funding for programs.*** Nearly all participants identified a lack of funding for programs as a significant barrier for improving addiction care for older adults. According to Mr. J, "with addiction, the funding is the biggest one… it's the biggest barrier…we could have all the great ideas and all the great minds working together but how do we implement and where is the money coming from?" (front-line worker, 10 yrs. addiction field). Study participants argued that funding impacted the number of services available, which resulted in long waiting lists, costly transportation to and from programs or doctor's appointments, lower wages for workers, fewer supports for caregivers, and a lack of aftercare and age-specific services for clients.

***Aftercare services.*** Several participants described aftercare services (programs provided once treatment is completed) as an essential component of care that could reduce the relapse potential of older adults by providing opportunities to interact with others in recovery in a peer support setting. Participants argued that aftercare services, such as case management, follow-up telephone calls, addiction-specific peer support, and housing and income supports were uncommon and rarely available in Hamilton. While there are some programs that provide aftercare services, participants argued that sometimes there were restrictions on who could access those services. According to Ms. J,

> I think it's more of an issue with after treatment. What supports are in place for after treatment? Housing is always an issue and also aftercare. They might seek treatment, get the help they need but when the treatment is done, what else? … So they can have everything in treatment and then they go back to the community and they have nothing. I think that is what actually is a barrier, not for accessing treatment, but after treatment when they are re-establishing themselves in the community. (manager/administrator, 7 yrs. addiction field)

Moreover, study participants highlighted the need for more low-income or supportive housing units. Ms. L stated, "the supportive housing, I wish we had more. I think that's just the nature of this… we always want to see more of what works" (manager/administrator, 6 yrs. addiction field).

Study participants also identified limited resources for addiction peer support in Hamilton as a barrier for supporting clients after treatment. Previous literature on mixed-age populations has demonstrated the benefits of addiction peer support as an effective aftercare program/service. Favourable outcomes range from increasing rates of abstinence, feeling supported and understood by peers, belonging to a community of

people committed to recovery, reducing levels of incarceration, speaking freely without fear of reprisal, increased mood, obtaining useful information/feedback, feeling “normal” rather than “unique,” and reduced mortality rates (Blondell, Behrens, Smith, Greene & Servoss, 2008; Masudomi, Isse, Uchiyama, & Watanabe, 2004; Kissin, McLeod & McKay, 2003; Felix-Ortiz, Salazar, Gonzalez, Sorensen & Plock, 2000).

***A lack of collaboration.*** A majority of participants described a lack of collaboration among service providers in the health and social service sectors as a contributing factor to many barriers encountered by older adults because it created what study participants called a “confusing system” and one in which older adults had to wait for services. Study participants viewed limited collaboration among service providers as stemming from limited knowledge of the services being provided by different programs as well as the reality of competition between programs and sectors for scarce system resources. According to Ms. A,

> I think [older adults] come with such a complexity of issues and I think each of the agencies or various service providers separately don’t have a true, full picture [of their concerns] and people are forced to repeat the same story to 5 or 6 or 7 different sources and probably most them are passing the buck, saying ‘oh, you need to take care of this before this can be done’…I don’t think there’s enough cooperation and collaboration and it makes people kind of lost in the system. I’m not an older senior and I would be lost and I’m pretty well equipped and pretty functional. I cannot imagine how hard it would be for somebody who is already in that fog of addiction and scared and not fully informed. It’s very confusing…the system is very confusing. (manager/administrator, 14 yrs. addiction field)

Previous literature confirms these findings. PSSS (2004) argued that a lack of collaboration creates a fragmented system, wherein services function in silos and older adults struggle to find the right path to appropriate supports and services. This is

particularly problematic and highlights the need for increased efforts between programs to collaborate with other services to provide a seamless, comprehensive continuum of care.

**Recommendations to Improve Addiction Services for Older Adults**

Study participants provided several recommendations for improving the current addiction system to better meet the needs of individuals aged 50 years and older. Many of the recommendations complement existing literature and address barriers identified as restricting access to addiction services that support goals of recovery and wellness in old age. Recurring recommendations from study participants included: increased access to programs that incorporate age-specific interventions; enhanced opportunities for education that target the unique needs of older adults with substance use concerns; increased collaboration and partnerships between service providers in the health and social service sectors; the implementation of an addiction-specific outreach service that provides care to older adults in their place of residence; and enhanced access to services that help people feel connected and support recovery in the community.

**Recommendation #1: Increase access to programs that incorporate age-specific interventions.** A majority of participants highlighted the need for increased access to age-specific services that could better address the needs of older adults. Participants generally defined the term "age-specific" services in 1 of 4 ways, which could be interpreted as 4 different levels of age-specific interventions. First, participants recommended that there be an increase in addiction programs geared specifically toward an older adult population. According to Ms. W, "I think we need to have a place that

services that age group individually… like a treatment centre specifically for older adults" (front-line worker, 12 yrs. addiction field). Some participants identified specific treatment programs, such as a residential treatment program, that would better address the needs of older adults if they were age-specific. For example, Ms. B stated,

> I would like to see that there would be a residential program that was barrier free and big enough to have a senior specialized component to it… it could be targeted so that it could be talking about issues that you have in that time of your life versus talking about the whole spectrum. (front-line worker, 7 yrs. addiction field)

This research finding was highly anticipated by the literature. Previous research on age-specific interventions and the perspectives of service providers have demonstrated a push toward more services that specialize in addiction care for older clients (Andrews, 2008; Dowling et al., 2008; Oslin, 2004; Blow et al., 2000; Atkinson et al., 1991; Kofoed et al., 1987). There is strong evidence that supports age-specific care as a best practice approach for treating older adults with addiction (Health Canada, 2002). Age-specific programming not only addresses lifestyle issues specific to older adults but it also addresses the social context of addiction, health issues, personal concerns, and offers the opportunity to create new social support networks that celebrate healthy and productive life decisions and discourage substance using practices.

Second, participants recommended that mixed-age programs add the "age-specific" component of care by organizing groups or providing activities specific to the needs and/or interests of older adults in their program. Interestingly, one study participant compared the provision of age-specific care in mixed-age programs to students choosing courses that spark their interest and/or needs in high school. According to Ms. M,

> If we could have more staff, more funding, [and] more space we could provide care like they offer courses in high school… where, you know, not everybody takes the same subject. This way we could definitely work towards meeting their specific needs. So for example, if we have 3 women that are in their 50s, well then they have a period of time in their treatment where they work on specific issues… so they are moving to different places to address different age-specific needs. (front-line worker, 23 yrs. addiction field)

This recommendation complements findings from Oslin et al. (2005), wherein scholars reported favourable findings regarding adherence to treatment among older adults that had access to age-appropriate psychotherapeutic strategies in a mixed-age treatment setting. Over the years, the recommendation to incorporate age-specific components of care within mixed-age programs have gained recognition and support, perhaps in part due to the fact that it permits existing programs to implement age-appropriate interventions as add-on services, thereby reducing the financial investment of individuals creating new age-specific programs or modifying mixed-age mandates to service only older adults.

Third, study participants recommended that mixed-age programs address the issue of pairing older adults with younger workers by employing front-line workers that are similar in age, have gerontological training and/or are respectful and aware of age differences. As a younger worker, Mr. J shared an experience of working with an older adult and described how he addressed the client's needs.

> I had a client in here who was 62 and the first thing I said was 'I just want to ask you if you are comfortable talking to me because I'm younger than you' because we had an older counselor that he could have gone with…but I think it all comes down to just treating them with respect, asking them and being sensitive to the needs of the person that your working with. (front-line worker, 10 yrs. addiction field)

At the very least, service providers proposed that programs employ workers that are aware and respectful of age differences, and have gerontological training. Study participants argued that this would reduce feelings of discomfort and resentment toward younger employees. Previous research conducted by Health Canada (2002) and PSSS (2004) have noted the importance of employing individuals who are interested in working with older adults or who have background knowledge of addiction from a gerontological perspective. The recommendation to employ older front-line workers adds to the existing body of literature on age-specific interventions and might be feasible for some agencies since they may already have older front-line staff members who would be interested in working with older clients. Furthermore, to assess the validity of this recommendation, it is imperative that future research involves the perspectives of older adults.

Fourth, study participants recommended that mixed-age programs tailor to the unique needs of older adults that access their services. For example, study participants recommended that programs lengthen treatment stays, shorten group sessions, limit the number of people enrolled in groups and offer groups at different times of the day to accommodate individual preferences for morning, afternoon and/or evening groups. Moreover, study participants mentioned the need to address physical barriers by providing access to bus passes in order to attend events/groups, and by providing reading glasses and/or making treatment material in a larger font to reduce the impact of visual impairments on program participation. According to Mr. F, "we need to be more adaptable to people rather than making them fit in…rather than saying you can't function

in our group, we need to adapt the program to what people can actually manage (manager/administrator, 30 yrs. mental health and addiction field).

**Recommendation #2: Enhance awareness among the general public, family members, older adults in the community and healthcare/social service workers regarding the unique needs of older adults and services available for addressing substance use concerns.** A majority of study participants recognized education as a crucial ingredient for better addressing the needs of older adults in treatment and reducing the stigma associated with addiction. According to Ms. P,

> Stigma comes from ignorance so I guess it's all about education…and sometimes that means educating the people who are stigmatized as much as the general population or front-line workers because we self-stigmatize and if we are not willing to get past [our self-stigma] then we can't expect anyone else to. So we have to find a way to stop putting ourselves down for our mental health and addiction issues because we didn't choose it. So we need to recognize that and that's going to take a little bit of education. (manager/ administrator, 15 yrs. mental health and addiction field)

In order to normalize addiction, reduce stigma and increase awareness among older adults, study participants recommended that service providers incorporate information on substance use during regular social activities with older adults. More specifically, Ms. X recommended that service providers increase awareness by targeting wellness and/or cooking workshops at community or senior centres to include information on harmful substance use as part of regular discussion. According to Ms. X,

> Sometimes we find that a lot of people [at community centres] don't want to go to the addictions 101 workshop because they assume that, 'if I walk through that door everyone will think that I have an addiction problem.' So if there is a wellness series taking place at a seniors centre and there is some discussion on medication, then they could add something in about substances or if there is a workshop on cooking and there is discussion on safety in the kitchen, then they

> could add a piece on avoiding the stove when they are drinking. I think it's about making [the topic of substance use] a part of your everyday curriculum because people are very hesitant about that. It's kind of looking at where do older adults access or start to access help and how do you sort of build awareness that substance use can be a problem. (manager/administrator, 16 yrs. addiction field)

***Increase knowledge of service providers about older adults and addiction.*** A majority of study participants recognized the need for cross-sector education on the prevalence of addiction, the clinical profile of older adults, successful treatment modalities for encouraging recovery, and the signs and symptoms of addiction in older adults. According to Ms. D,

> I believe the most pressing concern for older adults is the clinical piece, which is understanding what alcohol and substances do to a body as it ages and providing the right treatment for them…the other key piece would be learning about what works in order to get them into programming…I think practitioners who are working front-line need to have some more information…because we may not even be recognizing what some of their needs are because we're not perceiving them as being different…so we're lacking some knowledge. (manager/ administrator, 12 yrs. addiction field)

According to study participants, awareness of these issues would result in enhanced screening practices and greater detection of addiction concerns among older adults, which would inevitably lead to early intervention and prevention practices. This knowledge was perceived as imperative not only for mental health and addiction workers but also for front-line employees in the aging and social service sectors and among primary care physicians and other healthcare clinicians.

Previous literature concurs with these research findings. The PSSS (2004) study attests to the need for greater prevention/education resources for older adults, service providers, family members and the broader community to address addiction concerns

among seniors. The need for more education was also identified by Health Canada (2002) as a necessary component for effective screening and diagnosing. More effective screening and assessment practices will reduce the likelihood of long-term exposure to hidden and undiagnosed addiction and thus result in better health outcomes for older adults as well as reduced spending on health care and social services. Furthermore, these research findings point toward the need for future planning that strives to organize training opportunities for front-line service providers.

***Learning from older adults with addiction***. Study participants stressed the importance of learning from older adults with lived experience of addiction in order to enhance services and reduce barriers for seniors. Individuals with lived experience were not only described as experts of their own needs but also the barriers to treatment and were viewed as the best source of education for service providers. According to Ms. D,

> First, we need to ask people who are in that age category and second, we need to build programming with those people. We have to ask them to articulate what it is they need and what it looks like. Our work is to facilitate that happening and create opportunity for that to occur. (Administrator/manager, 12 yrs. addiction field)

Several study participants noted that learning from older adults with lived experience would take commitment from service providers and would require equal representation of older adults from different social locations; however, study participants viewed outcomes as far outweighing commitments. Study participants believed that the contributions of older adults would be highly valuable and would help older adults invest in their care. According to Ms. P,

I always think it’s best to go to the individuals who have the issue and truly find

> some way to get people involved because if they help themselves and they come up with the ideas themselves then they have made an investment and when you make an investment, you invest in yourself and you are more likely to make it work. (manager/ administrator, 15 yrs. mental health and addiction field)

This finding adds to existing literature that supports the need for involvement of family members and peers in the interventions offered to seniors (Health Canada, 2002). It views the perspectives of people with lived experience as experts in what older adults with addiction truly need. Not only does this finding draw on concepts used in the mental health field but it also draws attention to the emerging push in the mental health and addiction sectors to view people with lived experience as more than contributors but rather "directors" in care and experts in knowledge of the needs of others suffering from mental health and/or addiction concerns.

Study participants recommended several different methods for educating the general public, family members, older adults and professionals in the health and social service fields. Methods included: sharing information in the form of workshops, college courses, posters/pamphlets, TV and radio commercials, newspapers, websites, and communities of practice. According to Mr. J,

> Maybe [provide information through] a geriatric addiction course that they offer at Mohawk or an all-day workshop where they could renew their knowledge once or twice a year…or even to have posters up that look at the prevalence of addiction. (front-line worker, 10 yrs. addiction field)

Ms. B suggested that service providers educate older adults by putting information in "seniors magazines or seniors websites…letting them know that [addiction] is something to be alert about…that there is a risk and that treatment is available. So making it more normalized" (Front-line worker, 7 yrs. addiction field).

By advertising that older adults can suffer from addiction, that services are available to assist individuals with addiction and that recovery and continued autonomy are possible, older adults may be more likely to seek services and increased public awareness may reduce the stigma and discrimination associated with having lived experience of addiction.

**Recommendation #3: Increase efforts to collaborate and partner between service providers in the health and social service sectors.** Study participants put forth the recommendation that agencies increase their collaborative efforts to reduce barriers for older adults.

***Partner and share expertise.*** Study participants recommended that service providers increase partnerships, and share resources and expertise on the needs of older adults with addiction. For example, several study participants noted the potential benefits of consulting, partnering and/or strategizing with senior support organizations, such as long-term care homes, to exchange knowledge on addiction and learn more about the needs of older adults. Participants also saw a benefit to employing individuals with gerontological training and providing education on addiction to ensure that services are sensitive to the needs of older adults. According to Ms. M,

> It's unfortunate that you know there are agencies that work with seniors and we don't share our expertise. It's unfortunate that we don't have addiction workers that go and work with people who work with seniors and vise versa. It's unfortunate that we can't share our manpower…that we don't hire somebody whose training is in gerontology or has work experience with older adults because you can learn about addiction. (front-line worker, 23 yrs. addiction field)

This finding concurs with existing literature on recommendations for improving addiction treatment for older adults (PSSS, 2004; Health Canada, 2002). According to PSSS (2004), strategies for better addressing the addiction needs of seniors involve increasing linkages "between sectors and individuals within sectors serving seniors" (p. iii). This underlines the need for greater collaboration between service providers in the addiction and aging field. Opportunities to network between sectors should be supported through shared training events and/or formal linkages with organizations to share expertise on issues pertaining to aging.

A majority of study participants also described the need to increase partnerships with primary care physicians. Partnerships were defined as either employing addiction workers in primary care offices, employing doctors in community services to address medical needs outside of hospitals, providing addiction consults, and/or providing physicians with basic knowledge of older adults and addiction to increase their comfort with screening and asking the "right" questions about substance use.

Study participants described primary care physicians as the first line of care for older adults since they met with older adults on a regular basis. Participants viewed physicians as "authority figures" that could educate and motivate older adults to make healthy lifestyle changes. Thus, physicians were seen as an integral component of care for preventing illness and promoting wellbeing, and were viewed as being capable of screening for addiction in order to intervene early and prevent long-term use. According to Ms. B,

The positive side is that the doctor quite often brings them to treatment. So you'll

> ask them why they decided to come [to treatment] and they will respond, 'well, my doctor was concerned and the doctor said I needed to come here'. So that's a little boost that they need to get them to come…it's the authority of the doctor. They feel like [the doctor] is coordinating their treatment and if they are going to the doctor and they're coming here then they know that everybody is working in the same direction. I think that makes a big difference. They feel like they have a team behind them. (Front-line worker, 7 yrs. addiction field)

Moreover, partnerships with physicians were viewed as having the potential to improve access to, and awareness of services for family members and older people. These findings are well documented within the literature. Research by Lawton Barry et al. (2009) stress the importance of involving physicians that are knowledgeable in assessing the frequency of substance use among older clients. Moreover, Lawton Barry et al. (2009) delineate several useful recommendations for improving the readiness and awareness of physicians to accurately identify and address the needs of older adults, which highlight the need for enhanced training requirements for understanding effective screening, assessment and treatment practices for late-life addiction issues. Importantly, these recommendations for education requirements may take several years to implement within existing curriculums, thus the healthcare system should capitalize on the knowledge of current addiction service providers, particularly those that specialize with treating older adults, to assume a leading role in the dissemination of information among physicians regarding the special needs of older adults with an addiction.

***Help older adults navigate the system.*** Study participants highlighted the need for multidisciplinary teams that included access to case managers, social workers, nurses and physicians in order to address the health care needs of older adults simultaneously. According to Ms. A,

> There might be other things that contribute to addiction problems and if people are ready to start exploring them I don't think we should deny them that because of the fact that we don't have expertise on the team…we should have the expertise. So having more teams that are diverse in terms of their skill sets would be a good direction. (manager/ administrator, 14 yrs. addiction field)

Several study participants recommended that the system create an addiction specific navigator to effectively guide older adults through the system and ensure access to services. In fact, one study participant recommended the use of navigators located in emergency departments to begin working with people and connecting them to the community post-crisis. According to Mr. T,

> I think it would be really great if in the emergency room there was actually a navigator for addiction services. Somebody that could begin working with the person post-crisis and connect them to services in the community. (manager/ administrator, 43 yrs. mental health and addiction field)

This finding contributes to Canadian literature on addiction and older adults; research on older adults and addiction has not recommended the implementation of system navigators, nor studied the use of and/or benefits of system navigators. Nevertheless, there is a growing body of literature on system navigators in other health fields, such as mental health and chronic illness among older adults (Vedel et al., 2009; Manderson, 2011). For example, Vedel et al. (2009) developed a navigator position within a multidisciplinary team, consisting of primary care providers, an integrated team of case managers, and a community-based geriatrician. Preliminary findings demonstrated a reduction in health care services, specifically fewer hospitalizations, reduced emergency room use and a decline in unnecessary referrals to long-term care.

By reviewing literature on system navigators in other health areas, it becomes

apparent that the roles of navigator positions are highly variable and differ depending on the sector from which they derive. For example, the U.S., Patient Navigator Outreach and Chronic Disease Prevention Act of 2005 introduced a new patient navigator role to address the navigation needs of cancer patients (Darnell, 2007; Manderson, 2011). These navigators assumed the following duties: assisting with the coordination of services and referrals, facilitating involvement of community agencies/organizations, conducting outreach, helping patients overcome barriers in the health care system and managing relevant health information. These duties somewhat differed from navigator models that employed case managers to provide home visits and telephone support, patient advocacy, coordinate collaboration between health care providers and assist with care planning, and education (Manderson, 2011). While there is variation in navigator models, this recommendation may be a viable solution to reducing system confusion, improving the continuum of care throughout transition points and overcoming health and social service system gaps to ensure that older adults' needs are addressed.

**Recommendation #4: Increase addiction-specific outreach services to address the needs of older adults wherever they are located.** Several study participants highlighted the potential benefits of implementing an addiction-specific outreach team to address the unique needs of older adults in their place of residence. As noted by participants, potential benefits included, but were not limited to, reducing the use of preventable emergency department visits, reducing the number of phone calls made out to community agencies by hesitant and frightened older adults, addressing concerns with regards to autonomy and independence, social isolation, fear of stigma, leaving pets

behind and physical health limitations that would otherwise cause access barriers for older adults. An addiction-specific outreach team was also viewed as keeping people "connected to services" and "bridging the gap" between being enrolled in treatment programs and being placed on treatment waiting lists. Furthermore, an outreach team could encourage people to seek treatment early on, and provide a crucial opportunity for service providers to observe older adults in their environment to get a sense of life stressors that may be contributing to substance use. According to Mr. T,

> I would recommend that there be a mobile team that is related to addiction services for the elderly and that every single time someone is identified [as having an addiction concern] that services could contact this team and this team would go out to do further assessments and connect people to services…this [team] would help that individual identify some of their stressors that cause them to drink, what the pros and cons are and start looking at stages of change with that individual and providing motivational interviewing in their home. And then even if the person was on a waiting list then supporting that person until they actually get to the service (manager/administrator, 43 yrs. mental health and addiction field)

A few participants identified the potential benefit of having a community withdrawal management service (CWMS) much like the CWMS located in Halton through the Adapt agency. According to Ms. A, Adapt has "a community withdrawal service where a nurse and counselor go to the client's place of residence, of course at the client's request, and they stabilize them at home" (manager/administrator, 14 yrs. addiction field). Participants described this model as flexible and conducive to setting recovery goals of abstinence or harm reduction, as well as supportive in helping older adults remain in their homes longer and providing a form of social interaction that could reduce loneliness and improve overall life satisfaction.

This finding concurs with previous literature, particularly research by Health Canada (2002) which suggests that outreach services help overcome transportation barriers, senior's reluctance to seek help from community services due to historical contexts, social stigma, and distrust of services managed or organized by bureaucratic organizations or the government. Key experts from the Health Canada (2002) study furthermore, described outreach services as reducing anxieties by supporting clients in their own environment, building rapport, conveying trust and respect and an understanding of the client's lifestyle.

**Recommendation #5: Enhance access to services that support recovery.** Several study participants identified the need for greater access to services that support recovery for older adults. Some of the services that were identified as supporting recovery included the need for enhanced aftercare programs that keep people connected to services and peers, supports for safe housing and income, greater access to transportation services that are not restricted to "medical appointments" and addiction-specific peer support services.

***Increase aftercare supports.*** Study participants highlighted the need for increased access to aftercare supports for older adults completing treatment programs. Aftercare was defined as being connected to social groups composed of people in recovery, 24 hour telephone support lines and case managers that could help clients transition smoothly into the community, appropriate and affordable housing and access income supports in order to maintain independence and avoid relapse.

***Increase addiction-specific peer support services.*** Study participants continuously referenced the benefit of providing peer support services for people in recovery and those in the process of recovering from addiction (during and after treatment). They suggested that peer support services increased recovery rates, established social relationships with peers, which reduced feelings of isolation and loneliness, and was an "innovative", yet cost effective approach to sharing experiences, providing support, motivating change and maintaining recovery goals.

Previous literature on peer support and self-help reiterate this positive finding. In fact, there is a significant body of research that exists in the mental health field and focuses specifically on the benefits of peer support for people with lived experience of mental illness. While there is far less research on peer support in the addiction field, let alone with older adults, scholars nevertheless report that peer support fosters hope, creates opportunities for non-substance using social relationships, and gives people a sense of purpose in their lives (Health Canada, 2002).

Moreover, several participants highlighted benefits associated with interactions that took place between individuals in recovery (young and old) and individuals in the early stages of recovery. Some identified these interactions as naturally evolving into "mentoring" partnerships or "buddy systems" and producing positive outcomes not only for clients but also for individuals in recovery. Interaction with peers in recovery elicited the idea that recovery was possible; it created hope and inspired individuals in treatment to make changes and improve their lives. According to Ms. D,

My feeling is that people who are further along in recovery actually pull forward

> those who are not so far along in recovery because they show them what it looks like. So our men that come to day programming, whether they're older or younger, they inspire those who are still recovering or withdrawing. (administrator/manager, 12 yrs. addiction field)

When older adults were in recovery, they were described as playing the role of mentor particularly well. They often commanded respect, challenged inappropriate language, felt confident in what they could contribute to the recovery goals of younger peers, and shared their life experiences to deter younger peers from "making the same mistakes" that they had made. For younger clients, study participants believed that interaction with older peers in recovery gave them the opportunity to listen to older adults, ask questions and acquire important life skills. For older clients, study participants stated that interaction with older peers in recovery could provide them with an opportunity to interact with others that understood their experiences, and could reduce their feelings of isolation and embarrassment from going through treatment surrounded by younger people. Moreover, study participants stated that older peers in recovery would also benefit from interactions with younger and older clients because it would help them find "purpose in their addiction" by sharing their life stories and giving back to others. Thus, study participants recommended that services employ or seek older volunteers in recovery to provide support to old and young clients as a means of setting an example of recovery, helping older clients connect with others that are similar in age, and giving hope that change is possible.

This finding contributes to the existing body of literature on older adults with addiction by drawing attention to positive recovery outcomes that stem from social

interaction between people (young and old) in early stages of recovery and older people who are stable in their recovery and ready to give back. This finding warrants future attention from researchers who are interested in building the repertoire of knowledge on peer support, addiction and older adults, particularly those who are interested in exploring the relationship between people who differ in chronological age and are in different stages of recovery. One study participant concluded,

> We as counsellors are not as credible to our clients as other clients who are doing well… the relationships that they build and how they relate to each other can really inspire them, not only towards using [substances] together but also towards getting sober together.

Thus highlighting the need for addiction-specific peer support services and increased opportunities for peers in recovery to “give back” to those in early stages of recovery.

# IMPLICATIONS & RECOMMENDATIONS

Given the increasing prevalence of substance use concerns among older adults, the growing proportion of adults aged 50 and older, and the recent provincial emphasis on preventing diseases and containing health care costs, such as reducing ED visits and the institutionalization rates of older adults, it is important to consider the implications of this study for older adults, service providers, policymakers and future research.

**Implications and Recommendations for Older Adults**

This study found that there is one addiction service in Hamilton, and very few in surrounding areas that provide age-specific addiction care for older adults. In accordance with previous literature, this study confirms that access to age-specific care, while limited, is an integral component of the continuum of care for older adults; therefore, supports the need for additional age-specific approaches that enhance treatment outcomes for older adults.

Results reveal that older adults would benefit from more opportunities to engage in peer support relationships. Regardless of whether they are recipients of support or the benefactors in recovery, older adults should be given the opportunity to interact with other older adults to enhance their treatment experience and gain a stronger sense of belonging, peer acceptance and camaraderie. While interaction with peers is regarded as highly beneficial, this study highlights the need to give older adults an opportunity to

focus on their needs and recovery goals in mixed-age treatment programs before offering guidance and support or acting as role models to younger clients.

According to service providers, older adults would benefit from programs that offer services in their place of residence. Implementing an addiction-specific outreach service in Hamilton and surrounding areas would reduce fears of stigma, shame, discrimination and loss of autonomy, and would improve access to services for people that experience physical limitations, are distrustful of using hospital and/or community services or are placed on long waiting lists.

**Implications and Recommendations for Service Providers**

Findings from this study reveal that addiction service providers want to understand the needs of older adults, particularly the prevalence of addiction, the clinical profile of older adults, successful treatment modalities and the signs and symptoms of addiction. Some service providers explicitly expressed frustration and dismay with feeling unsure or incapable of meeting the needs of older adults; and this frustration was described as negatively impacting their job satisfaction. These findings highlight the need for increased opportunities for cross-sector training on gerontological issues associated with addiction. It also points toward the need for increased collaboration between agencies and sectors, specifically the addiction and aging sectors to provide effective age-sensitive care for older clients. Moreover, it highlights the need for stronger partnerships between agencies and primary care physicians to help older adults navigate the health and social service system, and feel supported and motivated to make change. These

multidisciplinary partnerships will ensure that they do not continue to fall through the cracks of system gaps and remain hidden "issues" in the community.

This study acknowledges the need for heightened awareness of older adults' needs among service providers. One of the main objectives of this study was to increase awareness of older adults with addiction and to encourage planning groups to identify strategies for addressing their needs. By the nature of this study, awareness of addiction among older adults improved since service providers were asked to reflect on, and consider the unique needs of older adults using their services. In fact, several participants noted that discussion during interviews helped them recognize the urgency of learning more about their older clients. Increased awareness among service providers serves as an early stepping-stone toward reducing stigma and discrimination and increasing public awareness. Furthermore, increased awareness is likely to improve agency screening practices, early detection of substance use concerns and reduce the likelihood of long-term, undiagnosed addiction (Health Canada, 2002).

While limited resources pose a significant barrier to the implementation of many programs, findings from this study reveal that there are several strategies that can enhance existing services to address age-specific needs. Study participants indirectly established 4 different levels of age-specific care: programs that are entirely age-specific; mixed age programs that provide age-specific groups; mixed age programs that either pair older clients with older workers or hire staff members with gerontological training or an interest in working with older adults; or mixed age programs that tailor their services to address unique needs. Depending on available resources, service providers can implement

different levels of age-specific care to improve services for older adults. Moreover, mixed-age programs that tailor their services to address the unique needs of older adults must employ strategies to ensure that older adults remain active participants rather than assume listening roles for younger clients in order to maximize treatment outcomes for older adults.

Moreover, findings from this research identify addiction-specific peer support as a service with high potential for producing favourable outcomes for older adults. In addition, service providers with limited resources can provide addiction-specific peer support with relatively little impact on their existing budget. Strategies for implementing an addiction-specific peer support geared for older adults would require a lead or "champion" that would (a) review best practices to identify and establish important components of peer support and incorporate these components into existing programs or as a standalone service, (b) consult with existing aftercare support groups in Hamilton to recruit older people in recovery that are interested in providing peer support to older people in treatment, (c) meet with management staff of organizations to negotiate strategies for incorporating age-specific peer support into the treatment plans of older clients, and (d) slowly initiate a connection between older people in recovery and older people in treatment. It will be important to establish relationships with peers in recovery while older people are in treatment to maximize the benefits of peer support and encourage long-term commitment. This will ensure that older adults feel supported and socially connected to others that share their goals of recovery before they complete their treatment plan and reenter into the community.

**Implications and Recommendations for Policy**

Results from this study highlight the need for increased funding that is targeted to the older population of people who are struggling with addiction concerns. While the Ministry of Health and Long Term Care (MoHLTC) and the Local Health Integration Networks (LHINs) have identified aging and addiction as priorities, they have introduced strategies that target them separately, such as the Aging at Home strategy and the LHIN's 10-year mental health and addiction plan entitled, "Every Door is the Right Door". Without establishing a priority that bridges addiction and aging, many organizations in both health and social sectors may be more likely to view this growing issue as less "urgent" because it is not a funding priority. In most cases, change is dependent on the LHINs recognition of this issue and its impact on the broader system. To address this issue and bridge both strategies, funding should be made available for outreach projects that support people who wish to remain in their place of residence for as long as possible. Projects that support independence and target older adults can build off of existing services that address mental health concerns, such as St. Joseph's Healthcare Hamilton's Crisis Outreach and Support Team (COAST[31]) or could reproduce services in other LHINs, such as Halton's Adapt program, which provides community withdrawal management services in peoples homes.

[31] COAST stands for Crisis Outreach and Support Team and is a program of St. Joseph's Healthcare Hamilton. COAST is a mobile crisis outreach service that is provided 24 hours a day, 7 days/week by a mental health worker and dedicated police officer from Hamilton Regional Police Service.

Moreover, as part of the HNHB LHINs new strategic plan entitled “ACTION,” projects that integrate care and improve system efficiency and effectiveness between sectors and agencies to enhance the client experience should be encouraged and funded. As such, the LHIN could fund projects that are built upon partnerships between senior organizations and addiction agencies, such as (a) shared educational opportunities on the topic of older adults and addiction, (b) seconding workers so that organizations for seniors have access to an addiction worker, either housed in the organization or on call, and vice versa, and (c) hiring consultant(s) to produce a resource pamphlet that includes accurate and up-to-date information on addiction services that can be shared in both the aging and addiction sectors to increase knowledge of existing services in their communities and regions, facilitate successful referrals that ease confusing transition points and support the client’s journey to recovery.

## LIMITATIONS OF STUDY

There were several limitations to this study that are worth noting. Firstly, in order to truly support system improvement, it is necessary to include the perspectives of all stakeholders to validate and establish common barriers and solutions. The sample population of this study consisted of 17 managers and 7 front-line employees from Hamilton services that provide support for people with an addiction. While the study population was fairly representative of addiction services in Hamilton and participants provided rich accounts of their experiences with older adults, it nevertheless provided a narrow perspective and understanding of addiction issues among older adults due to the fact that it did not include the voices of people with lived experience of addiction, social service providers in the aging field and primary care physicians.

Insufficient time and resources played a significant factor in the limited range of perspectives included in this research study. Thus, the characteristics, unique needs and barriers to services experienced by older adults were reported based on the observations of addiction service providers. It would have been valuable to include the perspectives of people with lived experience, since they are truly experts in what is needed to attain and maintain recovery goals.

Moreover, it would have been useful to include the perspectives of people working in the aging and social service fields; since, these individuals have regular contact with older adults that may be struggling with substance use concerns and would have a thorough understanding of the characteristics of older adults as well as the unique

barriers they face. This perspective would have made a valuable contribution to the data gathered in this research study, since some study participants admitted to limited interaction with older adults with substance use concerns, simply because when compared to younger clients there were fewer adults aged 50 or older that accessed their services. While this finding supports previous literature, which views addiction among older adults primarily as a "silent epidemic," it nevertheless points toward an important limitation of this study and the need for diverse perspectives when studying older adults with addiction concerns (Crome & Bloor, 2005b).

Primary care physicians were another potentially important perspective that was not included in the study. Previous literature highlights the potential benefits of primary care physicians in the early detection, prevention and treatment of older adults with addiction concerns (Lawton Barry et al., 2009; Health Canada, 2002; Coogle et al., 2000). In fact, one study participant in this study described the story of an older woman who felt supported and motivated to make change because her physician was directly involved in her treatment and supported her recovery goals. The primary reason for not including physicians in the study stemmed from the fact that addiction among older adults is a complex issue that impacts a variety of professions and thus, requires attention from different perspectives. Research on physician's perspectives would require a separate study in order to give justice to the issue at hand and ensure a rich analysis of data.

Although the researcher's supervisor was consulted for input on coding and themes, and feedback from thesis committee members were incorporated during final stages of the thesis, themes identified in this research study were formulated and analyzed

by the sole work of the researcher. According to Silverman (2010), sound methodological research includes involving others in the initial stages of thematic analysis to review codes and themes and assess the reliability of codes to ensure that content accurately and representatively portrays the data. Due to time constraints and limited resources, it was not feasible to have another person review codes and themes of the study; however, to mitigate this limitation, the researcher followed the detailed guidelines of Braun and Clarke (2006) in order to effectively conduct a thematic analysis of research findings. Moreover, a review of the literature reveals that themes generated by the researcher resonate with themes identified in previous literature on older adults and addiction.

# FUTURE RESEARCH

This study highlights the need for additional research from the perspective of older people with lived experience of addiction. It would be valuable to include this perspective since these individuals have expert, first-hand knowledge of barriers in the system and would help identify strengths and weaknesses of the system that could inform funding priorities of the LHIN. Currently, there is a paucity of research on system gaps and barriers from the perspective of people with lived experience; thus, future research should incorporate these views in order to consider all avenues of information to make effective system improvement.

In addition to people with lived experience, future research should explore the potential role of physicians in early detection, prevention and treatment of older adults. Previous literature has noted inconsistent screening, assessment and prescribing practices among physicians as potentially leading to and/or supporting substance use concerns, which points toward the need for future research (PSSS, 2004; Tamblyn & Perrault, 1998).

A significant body of literature exists on the benefits of brief interventions when used during physician consultations with older patients (Schonfeld et al., 2010; Coulton, 2009 Health Canada, 2002; Christensen et al., 2006; Crome & Bloor, 2006; Gordon et al., 2003; Fleming et al., 1999). Future research should observe the feasibility of implementing brief intervention strategies in primary care clinics. Potential avenues for change include, but are not limited to, (a) consulting with leads from previous projects

that have worked with physicians to administer brief interventions and copy their implementation strategies in Hamilton (b) building partnerships between addiction agencies and primary care physicians to offer consultation or employ addiction workers in primary care clinics (much like the Hamilton Family Health Team's mental health nurses); (c) incorporate training on screening, referral and treatment in residency programs for new physicians; and (d) provide mandatory workshops on addiction for physicians in collaboration with the College of Physicians and Surgeons.

Moreover, this study highlighted the benefits of outreach services, which can help people remain autonomous in their place of residence. Along the same line, homecare workers carry the potential to improve early detection, screening and treatment for older adults with substance use concerns, and can significantly improve access as long as continued support is provided in a non-punitive manner. Future research should explore the viability of training homecare workers to have basic knowledge of addiction: the signs and symptoms as well as appropriate screening and referral tools. It is important to recognize that many homecare workers are employed in precarious, highly stressful positions; however, this may address the significant number of older people who remain hidden in the community with substance use concerns. Given that homecare is provided to older adults that have illnesses, this will prove especially useful since previous literature has associated illness with increased likelihood of using substances (prescribed or not prescribed) as coping mechanisms for symptoms of depression and/or pain (Roe et al., 2010; CAMH 2008a; Health Canada, 2007; Sorocco & Ferrell, 2006; Health Canada,

2002). As such, this would be a viable next step for future research that aims to reduce the number of hidden, undiagnosed cases in the community.

Finally, future research should consider the impact of language and cultural barriers on the use of addiction services among Hamilton's ethnically diverse population. Results from this study suggest that a majority of Hamilton addiction services have limited language capacity and they often struggle with cultural barriers that impact the client's experience and willingness to seek help. Moreover, previous research has found a relationship between immigrant status and increased likelihood of experiencing mental health and addiction concerns (Agic & Scheffer, 2003; MIH, 2001; Hyman, 2001). Thus, future research should identify and address the needs of older adults from different ethno-cultural groups to increase access to, and availability of culturally appropriate addiction services.

# CONCLUSION

This study not only provided a valuable opportunity to explore the state of existing Hamilton services for older adults with addiction concerns but it also granted the opportunity to gain a better understanding of the barriers to treatment that older adults face, unique characteristics of older adults and recommendations for improving access to effective services that address their needs. Many of the themes reported in this study confirm findings from previous literature, which demonstrates the validity of findings in this research.

This study also generated several original findings that point toward the need for future research and are worth briefly noting. First, this research added to existing literature, which associated increased commitment to treatment among older adults due to access to age-specific addiction services or approaches. While this study confirmed this finding, it also revealed that older adults demonstrate a greater readiness for change and stronger commitment to fulfilling their treatment plan (when compared to younger clients) regardless of whether they are enrolled in an age-specific or mixed-age treatment program. This finding highlights stronger motivations for change among older adults, and future research should explore these motivations in order to implement effective outreach strategies for older adults that share similar motivations but are more reluctant to seek help.

Second, this research study found that many older adults used substances to cope with cumulative shame, which stemmed from unresolved, traumatic early-life experiences

that impacted their decision to seek help. This new finding supports principles of the life course perspective by highlighting the impact of early life events on late life experiences and furthermore, underlines the need for effective intervention for negative life events in early stages of life to reduce the economic, social and personal impact of long-term issues that lead to increased use of substances as coping mechanisms for unresolved pain or shame.

Third, this study not only confirmed previous findings regarding the value of age-specific services but it also added a new dimension to age-sensitive care. More specifically, this research found that older adults felt resentment or uneasiness when paired with younger workers and perceived them to have less knowledge and expertise of their treatment needs. Thus, service providers recommended that agencies pair older clients with counselors of a similar age to ameliorate this concern. In order to validate this new finding, future research should include the perspectives of older adults in recovery.

Fourth, this study revealed that older adults should not only be involved in the process of their care but they should *direct* their care and be viewed as experts in their treatment needs and services to produce positive recovery outcomes.

Fifth, this study generated new and interesting findings regarding the relationship between young and older clients in treatment. Some study participants viewed interaction between young and older people as a positive experience for older people, since they were given the opportunity to act as role models and finally give back to younger people. On the other hand, some study participants viewed this interaction as problematic due to the fact that it diminished attention to the needs of older adults, who became listeners

rather than active participants in treatment. In order to balance the need for age-specific care and give older adults the opportunity to "give back," some participants recommended that programs focus on the treatment needs of clients first and encourage older adults in recovery to volunteer in treatment programs to provide peer support to older and younger adults recovering from addiction. These findings added to existing literature and revealed the complex relationship between young and older people recovering from addiction or already stable in their recovery.

Lastly, this research study added to existing literature by identifying the need for system navigators to guide older adults through the addiction system and ensure that older adults do not fall through the cracks of system gaps. These research findings provide a more complete picture of system strengths and opportunities for improvement in order to enhance the current state of services for older adults with addiction. Furthermore, recommendations from the study not only offer direction for future research but they also serve as suggestions for future system improvements that may be useful for service providers in both health and social service sectors.

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# APPENDIX A
# Glossary

### Substance Dependence

CAMH (2008a) has identified several similarities between the concepts of substance dependence and addiction. Substance dependence can be characterized by its manifestation in the psychological and physical aspects of a human being. Psychological dependence occurs when an individual requires his or her given substance to function, feel comfortable and cope with everyday life. Physical dependence ensues when an individual's body adapts to, or builds a tolerance for, the presence of a substance, which will cause physical symptoms of withdrawal if the person decides to stop using the substance (CAMH, 2008).

### Addiction

Building on the concept of substance dependence, an addiction "always involves psychological dependence, but may or may not involve physical dependence" (CAMH, 2008, p.3). This definition of addiction is particularly true for older adults who fall into the late- versus early-onset group of people who use substances. Research findings suggest that some older individuals who develop late-onset substance use problems do not necessarily develop physiological dependence and therefore, may not experience symptoms of substance withdrawal (Fingerhood, 2000). In addition, older adults may be more likely to experience negative outcomes from low substance intake due to biological changes associated with normal aging (Cummings et al., 2008; Crome & Bloor, 2005b; Health Canada, 2002).

### Young-old versus old-old

Initially classified by Neugarten (1996), individuals aged 55 years or older have been divided by chronological age into the typologies of "young-old" and "old-old" (cited in Health Canada, 2002). The age of transition from young-old to old-old has been generally accepted as 75 years of age. While there is some debate over the usefulness and simplicity of this typology, some gerontologists have found it helpful to conceptualize the term "older adult", since it includes an age span of around 40 years. This typology helps others recognize the diversity of individuals who are deemed "older," and therefore increases the accuracy of findings leading to better, more appropriate care for older adults with lived experience of addiction.

# APPENDIX B
# Literature Review on Best Practice Treatment Approaches for Older Adults with Substance Use Concerns

## Treatment Approaches and Philosophies

The following appendix will investigate addiction treatment approaches for older adults with substance use problems. It will provide both a brief description of each treatment approach followed by a summary of previous literature pertaining to older adults. Treatment approaches to be discussed include the following psychosocial approaches: brief interventions, MI, cognitive behavioural approaches, group-based approaches, family involvement, narrative therapy and individual therapy. It will also discuss outreach services and pharmacological interventions.

**Brief interventions**

Health Canada (2002) notes that a continuum of severity of substance use problems exists, and individuals who experience mild to moderate difficulties are believed to comprise a majority of people using substances. For this reason, full substance abuse treatment is not always necessary, and problematic use can often be addressed by using less intensive treatment approaches such as brief intervention (BI) or MI. In fact, literature on BI reveals its effectiveness in not only promoting at-risk or non-dependent substance users to reduce use but also by identifying dependent or "addicted" clients and facilitating appropriate referrals to treatment programs (Health Canada, 2002).

According to Schonfeld et al. (2010), BI is a one-on-one counselling session that consists of an initial screening followed by 1 to 5 sessions of 10 to 30 minutes of advice, education, direct feedback, goal setting and MI (p.108; CAMH, 2011; Health Canada, 2002). Miller and Sanchez (1993) are acknowledged in the literature as coining the acronym FRAMES to represent 6 key elements of BIs known as, Feedback, Responsibility, Advice, Menu of strategies, Empathy and Self-efficacy[32] (Clay, 2010; Flood & Buckwalter, 2009; SAMHSA, 1998). The underlying goals of this treatment approach are to increase insight and awareness of substance use problems and to motivate behavioural changes that result in abstinence or reduced use of substances (Clay, 2010; Kalapatapu & Sullivan, 2010; Health Canada, 2002; SAMHSA, 1998). In addition, BIs can be provided by a variety of healthcare professionals, including substance abuse workers, nurses, physicians, dentists, psychologists, counsellors, home healthcare workers and social workers (Health Canada, 2002; SAMHSA, 1998).

[32] According to Clay (2010), feedback is provided on personal risks and/or impairments of substance use problems. Responsibility is the responsibility a practitioner places on the individual to choose whether or not to make healthy changes or continue using their substance of choice. Advice refers to the nonjudgmental advice a practitioner gives regarding change. Menu of strategies refers to the treatment alternatives and self-directed change options that are opportunities for making change. Empathy refers to the overall demeanor of the practitioner who displays warmth, understanding and respect, and actively and reflectively listens to the client. Self-efficacy refers to the optimistic empowerment that is provoked in the person to promote change.

While a majority of studies conducted on the effectiveness of BIs have focused on individuals with alcohol use problems; it is nonetheless important to note that literature on BI indicates that it is not only effective for older adults but it is also cost-effective and can be delivered in a variety of healthcare settings (Schonfeld et al., 2010; Coulton, 2009). Scholars suggest that the educational approach of BI helps the older adult understand reasons for, and consequences of their substance use, thereby increasing their sense of independence and ability to make personal changes. It also helps older adults recognize triggers and develop personalized methods to offset urges/circumstances that lead to substance abuse (Health Canada, 2002). In addition, BI is not time-consuming and requires few follow-up visits, which is especially significant given the number of positive research findings regarding its effectiveness.

A study conducted by Schonfeld et al. (2010) reported significant decreases in alcohol (81.1%) and drug use (75%) as well as prescription (32.1%) and OTC medications (95.8%) due to treatment that included 1 to 5 sessions of BI and a follow-up interview. The study was based in Florida, United States from 2004 to 2007 and included a study population of 323 older adults with an average age of 75 years. These recent findings illustrate the potential for BIs to improve medication, alcohol and illegal drug use.[33]

**Motivational interviewing**

Motivational interviewing (MI) entails the use of specific interventions that respond to an individuals' readiness for change[34] (Clay, 2010; SAMHSA, 1998). This treatment approach views each individual as capable of making changes to improve their lives and it assigns responsibility to the practitioner for helping each individual reach their potential (University of Texas [UoT], 2009). There are five basic MI interaction strategies that practitioners can use; these include open-ended questions, affirmations, reflections, summarizing and eliciting "change talk" (UoT, 2009, p.17). These interaction strategies are used to determine the individual's stage of change and furthermore, help facilitate the gradual improvement of increased insight, willingness to accept treatment and ambivalence to change (Clay, 2010).

There are several reasons why MI is an appropriate best practice, evidence-based approach for older adults with substance use concerns. UoT (2009) reveals that there have been more than 120 clinical trials on the effectiveness of MI, and this approach has been reported to complement other treatment methods such as BI and cognitive behavioural therapy (SAMHSA, 1998). Its ability to not only meet "people where they are" but also accept the individual's perspective as valid and a "starting point" for change has proven effective when working with older adults (Kennedy et al., 1999; SAMHSA, 1998, p.3).

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[33] Similar findings have been reported by Christensen et al. (2006); Crome and Bloor (2006); Gordon et al. (2003); and Fleming et al. (1999).

[34] Motivational interviewing uses the Stages of Change model pioneered by Prochastka and DiClemente. Clay (2010) clearly outlines the five key stages of change and appropriate motivational strategies for the practitioner to use with clients. The five key stages of change are: precontemplation, contemplation, preparation, action, maintenance and recurrence. For more information see Clay (2010) and Hanson and Gutheil (2004).

Using MI, the practitioner is able to foster a personal environment based on trust, respect and acceptance, and is able to avoid moralizing, confronting or labelling while continuing to place the responsibility for change on the older adult; all of these practices are complementary to the principles of age-specific care and tailoring treatment for older persons[35] (Simoni-Wastila & Yang, 2006; Sorocco & Ferrell, 2006; Hansen & Gutheil, 2004; Kennedy et al., 1999; SAMHSA, 1998).

A study conducted by Gordon et al. (2003) compared the effectiveness of MI, BI and standard care among 45 older adults (65 years and older) with alcohol use problems. The study found a statistically significant reduction in alcohol use for both MI and BI interventions and concluded that both approaches were equally effective in treating alcohol use among older adults (Gordon et al., 2003) [36].

**Cognitive Behavioural Approaches**

According to Sorocco and Ferrell (2006) there are three broad categories of cognitive-behavioural approaches known as, behavioural modification therapy, self-management techniques and cognitive-behavioural therapy[37] (SAMHSA, 1998). All three approaches share in the goal of helping the client learn how to identify and modify "self-defeating thoughts and beliefs" associated with substance use (Sorocco & Ferrell, 2006; SAMHSA, 1998, p.12).

Using a cognitive behavioural approach, the practitioner works with the client to analyze behaviours and construct a substance-using "behaviour chain," which includes antecedent situations, feelings, thoughts, drinking urges and cues that lead to substance use; the pattern and style of the substance-using behaviour; and positive/negative consequences that follow use (SAMHSA, 1998, p. 12). Following the development of a behavioural chain, the practitioner teaches the client, in a group or individual therapy setting, the skills necessary to cope with high-risk situations, thoughts or feelings using repetition and rehearsal techniques, "homework" assignments and feedback (Sorocco & Ferrell, 2006; Health Canada, 2002; SAMHSA, 1998).

Scholars report favourable findings with regards to the effectiveness of cognitive-behavioural approaches for older adults with substance use problems[38] (Han et al., 2009; Cummings et al., 2008; Dowling et al., 2008; Knight & Satre, 2006; Sorocco & Ferrell, 2006; Barrick & Connors, 2002; Health Canada, 2002; SAMHSA, 1998). Barrick and Connors (2002) argue that this approach not only reduces the risk of relapse, but is also at least as effective, if not more, for older adults when compared to their younger counterparts. This approach is also well suited to cope with difficult life events that accompany the aging process such as, physical decline, retirement and the loss of family and friends. It is also associated with decreased alcohol use, high rates of abstinence,

[35] See Hanson and Gutheil (2004) for an excellent explanation of how to use MI for older adults.
[36] For additional information on MI see Oslin et al., 2005.
[37] SAMHSA (1998) describes behavioural modification therapy as learning and conditioning ways to modify overt behaviours. Self-management refers to learning how to modify overt and internal behaviours, and cognitive-behavioural therapy refers to altering internal behaviours.
[38] Similar to other treatment approaches, a majority of literature on cognitive-behavioural approaches for older adults focused on alcohol use problems.

positive community adjustment and general health and wellbeing for older persons (Cummings et al., 2008).

There are concerns regarding the implementation and reinforcement of this approach for older adults with cognitive impairments; however, Knight and Satre (2006) argue that cognitive behavioural approaches are easily adaptable to many of the late-life challenges that older adults face, including cognitive changes associated with aging (Health Canada, 2002).[39]

In a study conducted by Schonfeld et al. (2000), cognitive-behavioural and self-management approaches were used to treat 49 individuals in an outpatient program. The treatment approach resulted in more than half (55%) of participants reporting abstinence at a six-month follow-up and an additional 27% reporting abstinence at follow-up with the exception of having one or more "slip ups". These findings ultimately illustrate the effectiveness of using this approach with older adults.

**Group-based Approaches**

According to Health Canada (2002) group therapy supports recovery by providing an environment where peers can connect and identify with one another while learning from the experiences of others. There is no limit to the number of years or the degree of involvement an individual can have in group therapy, especially due to the fact that professionals are not required to attend sessions, therapy is often costless and anonymity is guaranteed (SAMHSA, 1998).

SAMHSA (1998) argues that group therapy is particularly conducive to the needs of older adults. It not only provides an arena for practicing skills, giving and sharing information and testing perceptions with reality, but it also maintains an environment where people have the opportunity to learn self-acceptance by accepting others for their strengths and weaknesses and in return being accepted as well (SAMHSA, 1998). Furthermore, group therapy fosters a sense of community, camaraderie and high morale, and it allows people to deal with guilt and forgiveness by realizing that others have struggled with similar problems (SAMHSA, 1998).

While there are many benefits to group therapy, several scholars have expressed concern with regards to mixed-age groups that require older adults to admit to being an "alcoholic" as well as the confrontational approaches used to challenge people in denial (Roe et al., 2010; Benshoff & Harrawood, 2003; Colleran & Jay, 2002; Health Canada, 2002; SAMHSA, 1998). Scholars support the idea of providing age-specific group therapy to older adults and suggest that this treatment approach could create greater compliance, heightened bonding with peers and a greater sense of social support (Kuper et al., 2010; Sattar et al., 2003; Barrick & Connors, 2002; SAMHSA, 1998).[40]

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[39] Knight and Satre (2006) explore the use of cognitive behavioural approaches with cognitive changes associated with aging, emotional changes, cohort effects, social contexts of older adults and specific challenges/contributing factors that may lead to substance use, such as depression and chronic illness.

[40] SAMHSA (1998) identifies and describes four groups that are particularly advantageous for older adults. Groups include: socialization, therapy, educational and self-help or support groups[40]. Socialization groups help reduce isolation and loneliness and help build socialization skills so that older adults can meet new people and interact effectively with peers (Barrick & Connors, 2002;

A study conducted by Worley et al. (2010) revealed that group treatment, known as 12-step facilitation therapy, reduced the number of medication management visits to healthcare services. The study also found that high rates of group treatment attendance combined with cognitive-behavioural therapy led to shorter admissions for individuals hospitalized during treatment, which reduced the utilization of costly healthcare services. Other scholars also reported that group therapy led to increased rates of abstinence and reduced the risk of relapse in older adults (Kuper et al., 2010; Barrick & Connors, 2002) Thus, these findings highlight the potential benefits of group therapy for older adults with substance use concerns.

**Family involvement and therapy.** Literature on addiction among older adults rarely focuses on familial involvement in treatment. Perhaps this is due, in part, to the risks associated with family members who support continued use of substances and/or family members who are reluctant to discuss substance use out of fear of shame and discrimination for themselves and the older adult. Older adults also may not feel comfortable or feel like a burden discussing substance issues with family members present. Nonetheless, scholars note that family involvement carries the potential of generating positive outcomes for older adults seeking substance abuse treatment (Rosen et al., 2010; Sorocco & Ferrell, 2006; Barrick & Connors, 2002; SAMHSA, 1998).

According to SAMHSA (1998), family members, including adult children, are capable of playing a critical role in the treatment of older adults. In fact, married older adults are more likely to comply with treatment rules and regulations when spouses are involved in the treatment process (SAMHSA, 1998). Barrick and Connors (2002) state that familial involvement, whether it includes receiving information on how to deal with ineffective coping behaviours or being educated on the risks and needs of older relatives, reduces the risk of relapse and can help to bring closure to past conflicts and concerns (SAMHSA, 1998). In addition, a study conducted by Roozen, Waart and van der Kroft (2010) supports findings listed above by reporting that the Community Reinforcement and Family Training (CRAFT)[41] approach significantly increased the engagement of resistant older adults to enroll in treatment programs for substance use problems.

**Narrative therapy.** Narrative therapy is a new and emerging therapeutic alternative to treatment for older adults with lived experience of substance use (Gardner & Poole, 2009). Originally developed by White and Epston (1990), narrative therapy uses a postmodernist approach to counselling that is informed by the work of Michel Foucault

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SAMHSA, 1998). Therapy groups allow older adults to test their interpretations of social interactions, measure their responses and learn/practice new, more appropriate responses (SAMHSA, 1998). Educational groups provide older adults with information on addiction, support systems, medical aspects of aging and addiction (SAMHSA, 1998). Self-help or support groups are often incorporated into aftercare treatment plans for people using addiction services. For a comprehensive list and explanation of self-help groups, please see Colleran and Jay (2002).

[41] CRAFT is a treatment package designed to engage individuals who are resistant to go to treatment by working with concerned significant others (such as partners, family members and friends). This approach supports the belief that environmental contingencies can play a significant role in promoting treatment (Roozen et al., 2010).

(Gardner & Poole, 2009). This approach is centered on the belief that an individual's "identity is co-created in social, cultural, and political contexts" which is revealed through the narratives and stories of people (Gardner & Poole, 2009, p.601). Narrative therapists support individuals to look at their lives and experiences from a critical lens and they help individuals externalize problems by supporting them in the creation of alternative stories that separate individuals from their problems, otherwise known as "fighting back" (Gardner & Poole, 2009, p. 602). Narrative therapists also help individuals share their stories with others to assist in the process of making the reauthored story feel "real" (Gardner & Poole, 2009). [42]

Gardner and Poole (2009) and Poole et al. (2010) state that narrative therapy is effective for older adults because of its ability to help people examine their lives from a "survivor" not "victim" perspective. Furthermore, this approach offers older adults new ways to regain power over their lives and is "inspiring" in helping older adults reduce substance misuse patterns (Gardner & Poole, 2009). Gardner and Poole (2009) and Poole et al. (2010) both conducted research studies in Toronto, Ontario and found favourable findings that suggest that the practice of narrative therapy may become more prominent over the next few decades as a greater number of older adults seek treatment for substance use problems.

**Individual Therapy**

According to SAMHSA (1998), individual counselling/therapy is an effective treatment approach for older adults, especially in the beginning stages of treatment. Working one-on-one with the client, the practitioner is given the opportunity to support and encourage the client to overcome worries regarding privacy and judgment (SAMHSA, 1998). Moreover, the practitioner can use individual therapy to explain the basics and purpose of counselling as well as the roles and responsibilities of both the client and the practitioner in the client's treatment plan (SAMHSA, 1998).

SAMHSA (1998) states that practitioners working with older adults with substance use concerns must assure the client that sessions will be kept confidential and must conduct sessions in a self-contained, comfortable room that adheres to the older adults needs and preferences. In compliance with age-specific treatment, the practitioner should be supportive and non-threatening and should progress through therapy at a slow, respectful pace. In addition, the practitioner should summarize discussion at the beginning and end of therapy sessions and provide tasks for the older adult to complete between sessions to ensure that older adults understand the information being shared (SAMHSA, 1998). This inevitably leads to reduced use of substances or abstinence and can lower the potential for relapse in the future (Sattar et al., 2003; SAMHSA, 1998).

**Outreach Services**

Outreach services geared toward older adults with substance use problems include individual, family and group addiction counselling by trained professionals in their home or a preferred location (Fraser Health, 2011). Discussion topics can range anywhere from

[42] For more information on the stages and principles of narrative therapy see (Gardner & Poole, 2009).

ways to identify triggers, relapse prevention techniques and recovery strategies (Fraser Health, 2011).

According to Health Canada (2002), outreach services effectively respond to individuals living in the community with hidden substance use problems. Outreach services benefit the older adult because they are able to receive treatment in their own personal environment, which has been proven effective for older adults who are living with physical impairments that limit their mobility and/or access to transportation. In addition, outreach services address concerns from older adults regarding the social stigma and discrimination that is associated with being older and living with a substance use problem (Health Canada, 2002).

Health Canada (2002) reports on an outreach program based in British Columbia that offers a systematic approach to treatment for older adults. The program emphasizes personal empowerment and partnership, and provides older adults with education, family consultation and referral to appropriate treatment programs. Upon evaluation of the program, clients and outreach workers expressed great satisfaction with regards to increased feelings of self-efficacy and reduced substance use symptoms, both in terms of severity and frequency (Health Canada, 2002).

**Pharmacological Interventions**

There are several pharmacological interventions used to treat problematic substance use. Unfortunately, however, a majority of these interventions have not been studied or are understudied with populations of older adults (Dowling et al., 2008; Christensen et al., 2006; Oslin, 2004; Health Canada, 2002).

Research suggests that short-acting benzodiazepines, such as oxazepam or lorazepam, can be used for older adults with an addiction to prescription medications in withdrawal management treatment (Clay, 2010; Crome & Bloor, 2006). Clonidine and naltrexone can be prescribed for older adults with opioid addictions if use can be monitored closely. Alcohol-related vitamin deficiencies can be countered by prescribing folate, thiamine and multivitamin supplements (Clay, 2010). Other pharmacological interventions include disulfiram, acamprosate, chlormethiazole and carbamazepine; however, the use of these medications for older adults has not yet been confirmed for safe use.

It is important to note that pharmacological interventions for older adults have the potential to minimize withdrawal symptoms, reduce substance use and prevent future relapse; however, use of these medications should be closely monitored and provided in conjunction with other psychosocial approaches that combine to form the overall complete treatment “package” for older adults (Crome & Bloor, 2006).

# APPENDIX C
# Recruitment Email

## A Study on Addiction
## Treatment for Older Adults

**Cristina Merla BA,**
**Masters Candidate in Health and Aging**

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**E-mail Subject line:** A Study about Addiction Treatment for Older Adults

Hi Everyone,

Here is some information on a study that is being conducted by Cristina Merla, a Master's graduate student in Health and Aging at McMaster University. She is conducting a study to create a system overview of current Hamilton addiction services for older adults (50 years and older) with substance use concerns. She is interested in (a) the treatment approaches used by addiction service providers for older adults, (b) the unique needs of older adults with substance use concerns, (c) barriers that older adults face when accessing addiction services (d) an ideal and/or minimum list of services that are needed for older adults, (e) an identification of current addiction services that work well or require improvement, and (f) barriers/facilitators to operationalize service provider recommendations.

She will be conducting semi-structured face-to-face or telephone interviews that will take about 30-40 minutes of your time. As front-line workers in the field of addiction, she has identified all of you as ideal participants for her study. If you are interested in participating and/or have any questions about the study please contact her by telephone or email using the contact information listed below.

Your participation in this study will be confidential and I will not know who participates and does not participate in this study. Neither you nor our agency will be identified as taking part in this study in any thesis, report or publication that Cristina might produce based on your responses. If you agree to participate, you can decide to stop at any time. I have attached the interview guide and a copy of the letter of information about the study that gives you full details about her study. This study has been reviewed and cleared by the McMaster Research Ethics Board. If you any have concerns or questions about your rights as a participant or about the way the study is being conducted you can contact:

The McMaster Research Ethics Board Secretariat
Telephone: (905) 525-9140 ext. 23142

c/o Office of Research Services
E-mail: ethicsoffice@mcmaster.ca

**Cristina Merla** BA,
Masters Candidate in Health and Aging
Department of Health, Aging and Society
McMaster University,
Hamilton Ontario
Tel: 905 870-6192
merlac@mcmaster.ca

# APPENDIX C
# Recruitment Email

## Email Recruitment Script: Managers

**Cristina Merla BA,**
**Masters Candidate in Health and Aging**

## A Study on Addiction Treatment for Older Adults

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**E-mail Subject line:** A Study about Addiction Treatment for Older Adults

I am inviting you to take part in a semi-structured face-to-face or telephone interview that will take about 30-40 minutes of your time. As part of the graduate program in Health and Aging at McMaster University, I am carrying out a study to create a system overview of current Hamilton addiction services for older adults (50 years and older) with substance use concerns. I am interested in (a) the treatment approaches used by addiction service providers for older adults, (b) the unique needs of older adults with substance use concerns, (c) barriers that older adults face when accessing addiction services (d) an ideal and/or minimum list of services that are needed for older adults, (e) an identification of current addiction services that work well or require improvement, and (f) barriers/facilitators to operationalize service provider recommendations.

As a Manager/Administrator/Director of your service, I selected your name and contact information from an online search conducted through *Inform Hamilton* using the following key search term "addiction service." The Drug and Alcohol Registry of Treatment (DART) was also used to gather information on your agency.

There are minimal risks associated with this study. Neither you nor your agency will be identified as taking part in this study in any thesis, report or publication that I might produce based on your responses. If you agree to participate, you can decide to stop at any time. I have attached the interview guide and a copy of the letter of information about the study that gives you full details. This study has been reviewed and cleared by the McMaster Research Ethics Board. If you any have concerns or questions about your rights as a participant or about the way the study is being conducted you can contact:

The McMaster Research Ethics Board Secretariat
Telephone: (905) 525-9140 ext. 23142

c/o Office of Research Services
E-mail: ethicsoffice@mcmaster.ca

Please know that I recognize you are very busy and may not have time to participate in this study or may have received and responded to other research projects and may not wish to do another at this time. With this in mind, please know that this study is voluntary and I would like to thank you in advance for your time and consideration. After a week, I will contact you by telephone to answer any questions you have about the study and to seek your voluntary participation.

**Cristina Merla** BA,
Masters Candidate in Health and Aging
Department of Health, Aging and Society
McMaster University,
Hamilton Ontario
Tel: 905 870-6192
merlac@mcmaster.ca

# APPENDIX D
# Letter of Information/Consent

DATE: ________

**LETTER OF INFORMATION / CONSENT**

**A Study on Addiction Treatment for Older Adults**

**Faculty Supervisor**:
Dr. Margaret Denton
Department of Health, Aging and Society
Department of Sociology
McMaster University
Hamilton, Ontario, Canada
905 525-9140 x. 23923
mdenton@mcmaster.ca

**Student Investigator:**
Cristina Merla BA,
Department of Health, Aging and Society
McMaster University
Hamilton, Ontario, Canada
905 870-6192
merlac@mcmaster.ca

**Purpose of the Study:** You are invited to take part in this exploratory study on the perspectives of service providers regarding addiction treatment for older adults. I am doing this research to fulfill thesis requirements for my Master of Arts Degree in Health and Aging.

I am hoping to learn about the treatment approaches currently used by Hamilton addiction service providers for adults aged 50 years and older. I also hope to find out about the unique needs of older adults with substance use concerns, barriers that older adults face when accessing addiction services, an ideal and/or minimum list of services that are needed for older adults, current addiction services that work well or require improvement, and barriers/facilitators to operationalize Hamilton service provider recommendations.

**Procedures involved in the Research:** The face-to-face or telephone interview (depending on your preference) will take approximately 30-40 minutes to complete. The interview can take place in your office, via telephone, an office at McMaster University

or at a mutually agreeable off-site location. With your permission, I would like to use a tape recorder and/or take handwritten notes during the interview to ensure that data accurately represents your knowledge of addiction services. We will begin with some discussion on the addiction services that your agency currently provides for the general population and for older adults. I will ask you questions about the characteristics of older adults using your services, barriers faced by older adults with substance use concerns and the unique treatment needs of this population. I will also ask you about areas that need to be addressed within the addiction system and I will seek your recommendations for improvement. I will also ask you for some demographic/background information like your education, years of experience in the addiction field and your roles and responsibilities in your agency. Following the interview, I will review our discussion and may, with your permission, contact you for a follow-up interview.

**Potential Harms, Risks or Discomforts:** The risks involved in participating in this study are minimal. You may feel uncomfortable with answering some of the questions and you may worry that the researcher is assessing your personal ability to provide services to older adults with substance use concerns. However, it is important to know that the focus of this research is not on your performance as a service provider but rather the focus is on learning more about the topic of older adults and addiction and what in your opinion could contribute to serving their needs more effectively.

You do not need to answer all questions that make you feel uncomfortable. And you can withdraw from the study at any time, even after you begin the interview or once the interview is over. I describe below the steps I am taking to protect your privacy.

**Potential Benefits:** The research will be an opportunity for you to be able to share your valuable knowledge of the addiction system, the unique needs of older adults with substance use concerns and recommendations for improving services to better meet the needs of your clientele.

I hope that what is learned as a result of this study will help us to better understand the needs of older adults with substance use concerns. This could help Hamilton service providers and addiction planning groups prepare for future clients who are of increased age.

**Confidentiality:** You are participating in this study confidentially. I will not use your name, agency or any information that would allow you to be identified by others. No one but me will know whether you participated in the study unless you choose to tell them. However, if you chose to participate in this study at your office (in person or telephone)

during work hours, please make sure to choose a quiet, private location to ensure that your participation is anonymous. An off-site location a McMaster University will be available should you have any concerns with your privacy. Since your community is small, others may be able to identify you on the basis of references you make. Please keep this in mind in deciding what to tell me.

Identifying information will be replaced with acronyms and generalized names in interview transcripts and study notes. Data without identifying information will be shared with my supervisory committee. The information you provide will be summarized with the information provided by other participants. The information you provide will be kept in a locked cabinet where only I will have access to it. Information kept on a computer will be protected by a password. Once the study has been completed, the data will be stored for one year for future publication purposes. Once the study is complete, an archive of the data, without identifying information, will be deposited.

**Participation and Withdrawal:** Your participation in this study is voluntary. It is your choice to be part of the study or not. If you decide to be part of the study, you can decide to stop (withdraw), at any time, even after signing the consent form or partway through the study. If you decide to withdraw, there will be no consequences to you. In cases of withdrawal, any data you have provided will be destroyed unless you indicate otherwise. If you do not want to answer some of the questions you do not have to, but you can still be in the study. Your decision whether or not to be part of the study will not affect any of the roles (work or personal) you currently possess in the community.

**Information about the Study Results:** I expect to have this study completed by approximately September 2012. If you would like an executive summary of the results, please let me know how you would like it sent to you.

**Questions about the Study**: If you have questions or need more information about the study itself, please contact me by email: merlac@mcmaster.ca or by telephone: 905 870-6192

This study has been reviewed by the McMaster University Research Ethics Board and received ethics clearance.

If you have concerns or questions about your rights as a participant or about the way the study is conducted, please contact:

McMaster Research Ethics Secretariat
Telephone: (905) 525-9140 ext. 23142

c/o Research Office for Administrative Development and Support
E-mail: ethicsoffice@mcmaster.ca

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**CONSENT**

I have read the information presented in the information letter about a study being conducted by Cristina Merla of McMaster University.

I have had the opportunity to ask questions about my involvement in this study and to receive additional details I requested.

I understand that if I agree to participate in this study, I may withdraw from the study at any time. I have been given a copy of this form. I agree to participate in the study.

Signature: ________________________________________

Name of Participant (Printed) _____________________________________

*1. I agree that the interview can be tape recorded.*
*... Yes.*
*... No.*

*2. ...Yes, I would like to receive an executive summary of the study's results.*
*Please send them to this email address* __________________________________________
*or to this mailing address:*____________________________________________________

*... No, I do not want to receive an executive summary of the study's results.*

*3. I agree to be contacted about a follow-up interview, and understand that I can always decline the request.*
*... Yes. Please contact me at:* ______________________________________________
*... No.*

# APPENDIX E
# Interview Questions

**Interview Questions**
**Cristina Merla**
**A Study on Addiction Treatment for Older Adults**

**Question 1:** Please describe the addiction services that you provide within your organization.

**Question 2:** What are some of the basic characteristics of older adults using your service?

**Question 3:** How do your existing services meet the unique needs of older adults?

**Question 4:** Given the current addiction system, do you have any recommendations for supporting the needs of older adults in treatment?

**General/Demographic Information:**

Treatment setting: (medical program, outpatient program, residential program)
Treatment location: (hospital, community)
Academic background:

Current job title:
Brief description of your roles and responsibilities in your agency:
Do you provide direct clinical support to this population?
Number of years working in the addiction field:
Number of years working at specific organization:

# APPENDIX F



## Certificate of Ethics Clearance



McMaster University
Inspiring Innovation and Discovery

**McMaster University Research Ethics Board (MREB)**

c/o Office of Research Services, MREB Secretariat, GH-305, e-mail: ethicsoffice@mcmaster.ca

**CERTIFICATE OF ETHICS CLEARANCE TO INVOLVE HUMAN PARTICIPANTS IN RESEARCH**

**Application Status:** New ☑ Addendum ☐ **Project Number:** 2011 174

**TITLE OF RESEARCH PROJECT:**

Addiction Treatment for Older Adults: A Hamilton System Perspective

| Faculty Investigator (s)/ Supervisor(s) | Dept./Address | Phone | E-Mail |
|---|---|---|---|
| M. Denton | Health,Aging & Society | 23923 | mdenton@mcmaster.ca |
| **Student Investigator(s)** | **Dept./Address** | **Phone** | **E-Mail** |
| C. Merla | Health,Aging & Society | 905-870-6192 | merlac@mcmaster.ca |

The application in support of the above research project has been reviewed by the MREB to ensure compliance with the Tri-Council Policy Statement and the McMaster University Policies and Guidelines for Research Involving Human Participants. The following ethics certification is provided by the MREB:

☐ The application protocol is cleared as presented without questions or requests for modification.

☐ The application protocol is cleared as revised without questions or requests for modification.

☐ The application protocol is cleared subject to clarification and/or modification as appended or identified below:

**COMMENTS AND CONDITIONS: Ongoing clearance is contingent on completing the annual completed/status report. A "Change Request" or amendment must be made and cleared before any alterations are made to the research.**

| **Reporting Frequency:** | **Annual:** | **Other:** |
|---|---|---|

**Date:** **Chair, Dr. Br. Detlor:** [signature]

# APPENDIX G
# Codes

**Themes/Subthemes/Codes for Barriers**

| Theme | Subtheme | Code |
|---|---|---|
| Cultural Barriers | 1. Language barriers<br><br>2. Lack of knowledge regarding different cultural norms | - Lack of multilingual services, limited capacity to communicate in English, services not equipped to communicate in English, people do not seek help because will not understand, translators are costly, lack knowledge that services exist due to language barriers,<br><br>- Lack knowledge of different cultural norms and practices, service providers lack knowledge of different traditions, limited knowledge of culture impacts satisfaction, limited knowledge of culture impacts decision to seek help |
| Stigma | n/a | - Personal/self-stigma, internalization of stigma, generational stigma, stigma from religious norms/expectations, public perceptions that alcohol is a matter of choice/control, public perception that addiction drains resources, systematic stigma and discrimination, stigma impacting decision to seek help, stigma impacting research on addiction, |
| Psychological barriers | Fear of change and seeking help | - Do not believe change is possible, it is too late to change, lack hope and confidence to get better, addiction as one true pleasure, fear of losing friends/acquaintances if stop use, fear of isolation/loneliness due to overcoming |

| | | |
|---|---|---|
| | Shame | addiction, giving up substances which was important to them, fear of accepting addiction as a problem, fear of accepting a loss of control, fear of admitting the need for help, fear of losing autonomy/independence, fearful of leaving homes, fearful of leaving pets behind, fear of losing privacy/stigma,<br><br>-Regrets, pride and ego, cumulative shame, religious or generational norms/expectations that lead to shame, letting down families and loved ones, |
| Knowledge barriers | Older adults lacking knowledge of addiction services<br><br>A lack of system knowledge<br><br>Service providers lacking knowledge on the needs of older adults with an addiction | - Older adults lack knowledge of addiction system, - Lacking knowledge of services available, lacking knowledge that services are free, lack of knowledge due to isolation, lack of knowledge due to technology barriers, lack of knowledge due to little public education of addiction, lack of knowledge due to lack of collaboration/confusing system<br><br>- Lack of knowledge on addiction services, lack of knowledge on social/aging services, lack of knowledge leading to improper referrals, lack of knowledge leading to duplicate services, lack of knowledge leading to reduced access<br><br>- Lack of knowledge regarding characteristics of older adults, lack of knowledge regarding strategies for getting older people to access treatment, lack of knowledge regarding prevalence/severity, lack of knowledge on how substance affect an aging body, lack of knowledge on withdrawal needs, lack of knowledge leads |

| | | |
|---|---|---|
| | | to poor assessment/screening |
| Physical and structural barriers | Medical and physical limitations | - Issues with medication, physician prescribing practices, physician's lack of knowledge regarding older adults, and services lacking resources to address medical needs, mobility/sight impairments, physical layout of programs, wheelchair accessibility, transportation barriers. |
| | Co-occurring mental health concerns | - Limited capacity to address concurrent disorders, complex needs for people with concurrent disorders, group interactions for people with concurrent disorders. |
| | A lack of age-specific or age-sensitive care | |
| | *Subtheme: treatment support from young addiction workers* | -Uncomfortable with younger workers/new college graduates |
| | *Subtheme: mixed-age programs* | - Barrier to fit in with younger clients, different attitudes/beliefs among young and old, different life experiences/life stages, believing that addiction problems are not as bad as younger people, expectations that older adults are more nurturing, expectations of younger clients leading to negative outcomes, expectations of younger clients leading to positive outcomes, services lacking age-sensitivity, the need to be flexible in mixed-age programs for older adults |
| | A lack of funding for programs | - Lack of funding leading to waitlists, lack of funding leading to costly transportation (not covered), lower wages for workers, fewer supports for caregivers and lack of |

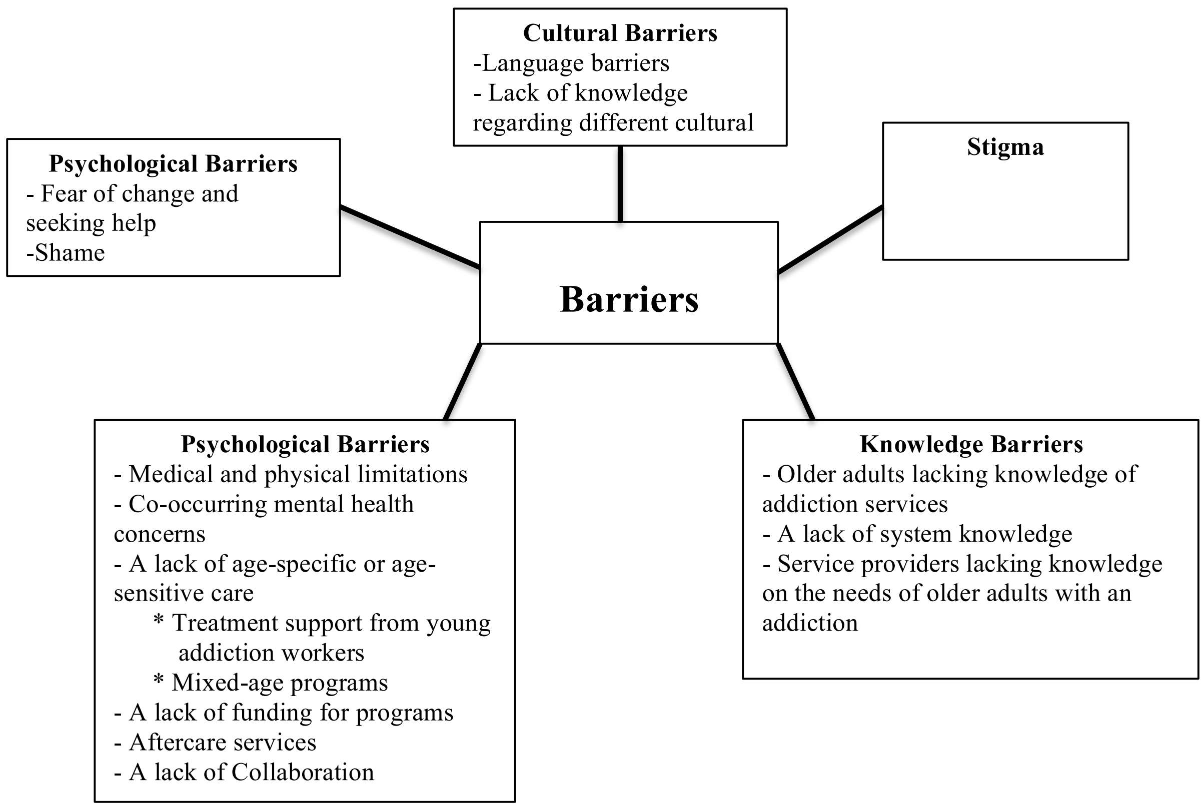
| | | |
|---|---|---|
| | | age-specific care |
| | Aftercare services | -Follow-up telephone calls, addiction specific peer support, housing and income supports |
| | A lack of collaboration | -Leads to confusing system, stemming from limited knowledge of programs, stemming - ---- Leads to confusing system, stemming from limited knowledge of programs, stemming from competition for scarce resources, from competition for scarce resources, |

**Themes/Subthemes/Codes for Recommendations**

| Theme | Subtheme | Code |
|---|---|---|
| Increase access to programs that incorporate age-specific interventions | | -Treating each individual uniquely, matching older workers with older adults, gearing services specifically toward the needs of older adults, add age-specific component to mixed-age treatment programs, employ workers that are aware of age differences/have gerontological training, address physical barriers, use specialized tools to meet needs of older adults, |
| Enhance awareness among the general public, family members, older adults in the community and healthcare/social service workers regarding the unique needs of older adults and services available for addressing | Increase knowledge of older adults and addiction | -Cross sector education on the prevalence of addiction, cross sector education on the clinical profile of older adults, cross sector education on successful treatment modalities for encouraging recovery, cross sector education on the signs and symptoms of addiction in older adult, education leads to enhanced screening practices and greater detection of addiction concerns among older adults, education leads to |

| | | |
|---|---|---|
| substance use concerns. | | early intervention and prevention practices. |
| | Learning from older adults with addiction | -Older adults are experts of their needs, potential methods for education |
| Increase efforts to collaborate and partner between service providers in the health and social service sectors. | Partner and share expertise. | - Share resources, increase partnerships with senior agencies, increase partnerships with primary care physicians, benefits of partnerships, access to care in a timely manner, collaborate to create a continuum of care. |
| | Help older adults navigate the system | - Create multidisciplinary teams to create a continuum of care, create addiction specific navigator. |
| Increase addiction-specific outreach services to address the needs of older adults wherever they are located. | | - Meet needs of older adults in place of residence, reduce stigma, reduce emergency department use, reduce number of calls made to community agencies, address autonomy and independence concerns, reduce social isolation, reduce fear of leaving pets behind, reduce physical limitations of programs, bridge gaps, keep people connected, observe home environment for life stressors, implement community withdrawal management services. |
| Enhance access to services that support recovery. | Increase aftercare supports. | - Increase access to affordable housing, increase access to income supports, and create 24-hour telephone crisis line specific to addiction. |
| | Increase addiction-specific peer support services | - Provide addiction specific peer support, create mentoring relationships/buddy systems, positive relationships between older people in recovery and younger people recovering, |

# APPENDIX H
## Mind Maps: Barriers



## Mind Map: Recommendations