Model to Assess Community Services for the Elderly Alcoholic

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AWARENESS OF ALCOHOL ABUSE AND ALCOHOLISM among the elderly has been increasing recently. Estimates of prevalence vary, but there is recognition at the national level that a significant number of people 60 years and older have problems with alcohol (*1*). Conservative estimates indicate that 1.6 million Americans 65 years and older are alcoholics (2). The elderly now constitute about 11 percent of the total population, and it is estimated that, by the year 2025, nearly 17 percent of the population will be in this age category. An increase in the number of elderly alcoholics can therefore be anticipated.

In general, their problems and needs have been ignored by both service agencies and social analysts. No research concerning this group was done before 1959, and indepth analysis began only in the 1970s ("Alcohol Abuse and the Aged." by P. G. Marden. Statement prepared for the Division of Special Treatment and Rehabilitation Programs, National Institute on Alcohol Abuse and Alcoholism, 1976). Although the data indicate that the proportion of abstainers increases with age and that the proportion of heavy drinkers declines after age 65, there is some evidence that the incidence of alcohol-related problems and alcoholism among the elderly has been underestimated (*3*).

It is believed that each community should assess its capabilities in reaching the elderly alcoholic and that all agencies serving the elderly, as well as those serving alcoholics, should participate in this effort. A community survey of the health care system is necessary to find out what resources exist as well as what services are needed. This effort should precede planning for comprehensive services in anticipation that the need for these services will increase in the future.

At present, the responsibility for the delivery of services to the elderly alcoholic is not clearcut. Agencies at the Federal, State, and local levels responsible for services to the elderly and to alcoholics may view this problem from different perspectives, but their efforts to alleviate it must be complementary and integrated rather than fragmented, duplicative, or even contradictory. Planning for the elderly who have alcohol-related problems or are alcoholics is at the formative stage, and solid information that can serve as a basis for planning is needed.

Overview of Assessment Model

The assessment model is based on a fundamental understanding of alcoholism as a complex problem. An added complication imposed by age is that at least three distinct groups of elderly persons manifesting alcohol problems have been identified: (*a*) the person with no history of a drinking problem before old age who has turned to alcohol in response to developmental stages inherent in the aging process (loss of significant others, retirement, and so forth); (*b*) the person who has intermittently experienced problems with alcohol but did not develop patterns of alcohol abuse until old age; and (*c*) the person typically defined as alcoholic throughout adult life (*3*). These categories are labeled in the literature by a variety of terms including late onset, late onset exacerbation, and early onset (*4*).

The model addresses prevention as well as treatment and control. The ingredients for a comprehensive program are well known to workers in the alcoholism field, but they are not so well known to those working in other health and social welfare systems. Because of

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widespread discrimination or indifference to the plight of the alcoholic, or both, specialized services for alcoholism have developed apart from the mainstream of other health and social agencies and institutions. As a result, knowledge and experience in treating alcoholism is not as widespread as it should be.

Mayer, in her review of research on alcoholism among the aged, points out that the phenomenon is acknowledged, but its existence is poorly documented and, thus, it is not a well understood condition (*5*). The paucity of descriptive data makes it difficult to formulate a cohesive and comprehensive overview. Planning should encompass techniques for estimating the incidence and prevalence of alcoholism by using standard formulas such as those developed by Marden ("A Procedure for Estimating the Potential Clientele of Alcoholism Service Programs" by P. G. Marden. Statement prepared for the Division of Special Treatment and Rehabilitation Programs, National Institute on Alcohol Abuse and Alcoholism. Undated). Community surveys, data from existing agencies, and information from those who, although not service providers, may be in contact with the elderly alcoholics (liquor store dealers, police, bartenders, managers of high rises for the elderly, and so forth) can illuminate the profile of alcohol abuse in the community.

Blacker has stated that the determination of need establishes the basis for planning and implementing programs of treatment and prevention of alcohol abuse and alcoholism (*6*). However, he has also indicated that, although knowledge of the epidemiology of alcoholism is essential for understanding the needs of the target population, other factors must be considered. Statistical data are important in stressing need for services; however, alone, they are insufficient for determining the types of services wanted or needed. Statistical data can indicate how many people to plan for, but not necessarily the type of services or activities required by the target population. The needs of the client population can best be determined by obtaining additional information from sources such as surveys of the elderly as well as the service providers currently working with them.

The model is based on the premise that the nature of the client population's problems should govern the design of the network of services. The model was developed in part by Edward Blacker, PhD, Director, Division of Alcoholism, Boston Department of Public Health (*6*). Kola used it to prepare portions of the Massachusetts State Plan for the Prevention, Treatment, and Control of Alcohol Abuse and Alcoholism in February 1972. The model attempts to assess three levels of need that comprise a total systems approach to planning: client level, agency level, and community level.

Client Level Needs

The problems, deficiencies, and needs of the elderly alcoholic on a clinical level are multiple and multifaceted. Among them are physical impairments, emotional and psychological strains and stresses, and difficulties with finances, housing, employment, and with family and social relationships. Clearly, alcoholism can seldom be overcome by a single solution; rather, the needs vary so from one alcoholic to another that only comprehensive services can meet them. A comprehensive program consists of five kinds of services: (*a*) emergency 24-hour care, (*b*) inpatient care (*c*) outpatient care, (*d*) intermediate care, and (*e*) consultation and education. The complete array of services to meet needs on the client level are enumerated in the box on page 460.

The need for each service requires careful analysis and evaluation. In the model the analysis covers the following 11 areas.

1. Demand. Although estimates of the prevalence of alcoholism among the elderly can be calculated, the incidence of demands for various services is less well known. Therefore, educated guesses have to be based on agency and clinical experience.

2. Current resources. Information about current services can be obtained from directories and local informants.

3. Adequacy of the community's resources. Evaluation may be done with a simple numerical system ranging from no service, very limited resources, programs adequate to meet current needs, and programs adequate to meet current and future needs.

4. General gaps and problems. Once the adequacy of resources relative to demand is evaluated and rated, an examination of areas 1, 2 and 3 should reveal gaps and problems in the available programs.

5. Recommendations. Specific recommendations and commitments should be made to remedy the deficiencies noted previously.

6. Target groups. Specific groups might include institutionalized elderly, elderly in general hospitals, elderly in golden age centers, and so forth.

7. Objectives. All objectives of a comprehensive alcoholism program for the elderly cannot be achieved simultaneously. Planning, promoting, and developing the program, manpower recruitment, financial limitations, and similar factors all limit the pace of implementation. Specific objectives are selected that can reasonably be achieved.

8. Personnel. Personnel who are needed to accomplish specific objectives are listed.

9. Budget costs. Costs of every program component are estimated.

10. Sources of financing. Possible sources might include Federal, State, local government, and private funds.

11. Priorities. For each specific objective, priorities are set. Objectives are considered as a whole in assigning priorities.

The full array of services in a comprehensive program is not required by every client. The particular constellation of problems and deficiencies associated with alcoholism varies from one alcoholic to another, and it is a serious mistake to think that all alcoholics are alike. In addition, many reports in the literature indicate that there are special problems in serving the elderly alcoholic which may or may not be addressed by categorical alcoholism agencies ("Alcohol Abuse and the Aged," by P. G. Marden, Statement prepared for the Division of Special Treatment and Rehabilitation Programs, National Institute on Alcohol Abuse and Alcoholism, 1976). Schuckit and Pastor have demonstrated that the elderly have a low rate of social-psychological problems but a high rate of physical problems that are not easily handled within alcoholism agencies and, in some cases, even preclude their being admitted (*7*). Carruth and co-workers have suggested that the elderly problem drinker population is not homogeneous, and problems of definition and diagnosis exist that pose barriers to accessibility of services (3).

The array of services for the elderly with alcohol problems or alcoholism must be put together with the recognition that the elderly do not always manifest the traditional symptoms of alcoholism, and that older people with drinking problems may not be regarded clinically as alcoholics. Ramifications of alcohol abuse may be manifested by elderly persons in accidents, by deterioration of a medical condition, and by adverse reactions caused by the interaction of alcohol and medication. Traditional views of treatment for those who are abusing alcohol may need to be altered. Rosin and

Services at Client Level

24-Hour Emergency Services

A. Medical treatment
   1. First aid
   2. Short-term detoxification
   3. Diagnosis and evaluation
B. Emotional
   1. Crisis counseling
   2. Social services
   3. Diagnosis and evaluation
   4. Referral
C. Other
   1. Outreach
   2. Transportation
   3. Shelter, including food

Inpatient Services

A. Diagnosis and evaluation
B. Medical care for detoxification
C. Medical care for physical complications of alcoholism
D. Psychiatric services
E. Social services

Outpatient Services

A. Clinic care
   1. Information and referral
   2. Diagnosis and evaluation
   3. Social services
   4. Medical
   5. Psychiatric
   6. Counseling
   7. Family counseling
B. Job assistance
   1. Job finding
   2. Job training
   3. Sheltered workshops
C. Other
   1. Legal aid
   2. Financial assistance
   3. Alcoholics Anonymous

Intermediate Care Services

A. Partial hospitalization
   1. Day center
   2. Night center
B. Drop-in center
   1. Recreation
   2. Education
   3. Information
   4. Referral
   5. Social club
C. Housing
   1. Halfway house
   2. Graduate house
   3. Lodging homes
   4. Foster homes
   5. Cooperative apartments
   6. Overnight shelter

Consultation and Educational Services

1. Informational and referral
2. Technical assistance
3. Training programs
4. Educational programs
5. Coordination

Glatt suggested that the elderly often develop drinking problems in response to losses inherent in the cycle of aging, and treatment needs to be focused on social environmental support rather than on the consumption of alcohol (*8*).

All these issues that focus on the recognition of the needs of the elderly and their responsiveness to treatment must be analyzed in the context of the five broad kinds of services, shown in the box on page 460, and the treatment models within them. For example, the finding that 85 percent of alcoholics who are elderly remain unidentified and untreated points to a need for unique and innovative strategies to reach this population (*9*). Zimberg stated that "treatment interventions will be much more effective when delivered through facilities serving the aged . . ." (*10*). Many of the agency administrators surveyed in an exploratory study of nine categorical alcoholism programs in Cleveland, Ohio, believed that staff in services for the aged had no expertise in diagnosing and treating alcohol abuse and alcoholism (*11*). These issues can only be clarified through further research into the nature of drinking problems of the elderly, the barriers preventing them from seeking treatment, and possible programmatic solutions to bring about the most effective interventions.

Agency Level Needs

In addition to ascertaining the services and treatment interventions that the elderly problem drinker requires, it is equally important to assess the existing agencies that serve or have the potential to serve this group. On a systems level, the gaps and deficiencies that prevent agency staff from effectively serving elderly persons with alcohol-related problems or alcoholism should be explored.

It has been demonstrated that rates of alcoholism differ among cultural and national groups. Explanations for the differences have been sought in the society's total drinking norms, with the suggestion that the attitudes and values placed on drinking behavior in a community contribute to the development of alcoholism (*12*). Attitudes also help to shape the alcoholic's illness career and the community's resources, as well as the quality and quantity of care provided by agency staff. Negative attitudes of society toward the alcoholic, and those of the helping professions specifically, have been well documented (*13*). Many caregivers' attitudes toward the elderly appear, in general, to be negative and to reflect ageism (*14*), and these may contribute to the finding that the majority of older alcoholics remain unidentified and untreated.

Clients depend upon agencies for services and, therefore, agencies have to be appropriately prepared to deliver effective care. To insure that agencies are fulfilling their purposes, they must be assessed in the following areas of competence: policy, treatment philosophy and practice, continuity of care, recordkeeping, manpower, knowledge and training, accessibility of resources, and funding.

1. Policy. Basic to a model program is commitment of the agency's staff; resistance to serving both alcoholics and older persons needs to be explored. Negative attitudes are often veiled in excuses such as other problems have higher priority, clients are not motivated, and so forth. These feelings have to be directly confronted and eliminated on all levels—general staff, administrative staff, and boards. Clients cannot be treated in an atmosphere of hostility or indifference. Both formal and informal policies are assessed for concrete manifestations of commitment to the treatment of the elderly alcoholic. Kola and Kosberg found that, although there was no overt discrimination against the elderly alcoholic in the alcoholism agencies they surveyed, most groups had a policy of restricting admission to persons who were ambulatory and not experiencing disabling medical problems (*11*). Such policies may be considered discriminatory, and programs must be examined in terms of discrimination on the basis of age, gender, race, ethnicity, and physical health or impairments, as well as the ability to pay.

2. Treatment philosophy and practice. Because the range of problems encountered by the elderly alcoholic may differ from those of the younger alcoholic, issues of treatment philosophy and practice are important in delivering services. Assessment should include the staff's recognition of the need for differential diagnosis as well as for different models of intervention. Treatment outcomes for the elderly must also be understood in the context of the problems encountered.

3. Continuity of care. Intramural and extramural linkages are essential to insure continuity of care. The needs of the elderly alcoholic cannot always be met by a single agency or a specialized alcoholism service. Joint planning, as well as formal working agreements and collaborations between agencies serving these populations, is called for. Kola and Kosberg found that the staff of alcoholism agencies often worked with the agencies serving the elderly, but only on a case-by-case basis and without benefit of formal agreements. Assessment at the agency levels must focus on the extent to which these linkages occur and are formalized (*11*).

4. Recordkeeping. Agencies must be able to account for their activities. Adequate record systems can identify the alcoholic elderly and allow a review of administrative procedures. Records should be maintained by all

involved agencies to (*a*) improve collaboration and referral between treatment agencies, (*b*) facilitate evaluative studies, (*c*) obtain additional information for planning purposes, and (*d*) make possible a range of research studies (*15*).

5. Manpower. The manpower situation of many agencies is frequently unsettled. Many types of personnel are in short supply, and agencies cannot always attract and keep competent staff, often because of low salaries. These problems can be partly minimized by more efficient use of existing staff and the employment of paraprofessionals—especially recovering alcoholics and volunteers who are familiar with alcoholism.

6. Knowledge and training. Staff of most agencies serving the elderly are not knowledgeable about the treatment of alcoholism, and staff of specialized alcoholism services similarly do not know about the older person's need for other services. To improve the knowledge base of both types of service providers, inservice training programs should be encouraged and agencies should collaborate on interagency efforts. Such training would also promote interagency linkages. Training should include not only theoretical knowledge about this special group but also information about the community's resources that might be effectively used. Assessment should focus on the type and number of training sessions that the agencies provide for their staffs.

7. Accessibility of resources. Facilities that are geographically remote or are not open at suitable hours constitute barriers to the elderly alcoholic. The elderly must spend most of their income on food, housing, and medical care, and they may be unable to afford public transportation or to maintain an automobile. Lowy indicated that the most serious obstacle to transportation for the elderly is their psychological reluctance (*16*). Assessment of the agency includes looking at the location of its facilities in respect to psychological access (that is, issues of safety) and physical convenience (easy access for those with limited ambulatory capacities).

8. Funding. Many agencies may want to improve their services to the population of elderly alcoholics, but they are constrained by lack of funds. Agencies need to be alert to all sources—both private and local program funds as well as all forms of third-party payments for services.

Community Level Needs

It has been suggested that appropriate attitudes toward the elderly and the problems of alcoholism must be engendered before an effective health care delivery system can respond to these problems. Appropriate attitudes pertain not only to the client and the agencies involved, but the entire community must also recognize its responsibility to integrate efforts at all levels of prevention. No health problem can be effectively solved until a means of primary prevention is discovered. Unfortunately, the current level of knowledge about alcoholism does not permit the application of traditional means of primary prevention, such as vaccines, that are available for other illnesses.

Today we have sufficient indications that many people drink to excess to cope with problems inherent in the process of aging—loss of job, loss of spouse, retirement, and general physical decline. Such changes make aging more difficult. Certainly, the general social and economic environment of the elderly should be examined. It is difficult to say, in quantitative terms, how factors of retirement, poverty, minority status, urbanization, poor housing, and poor health contribute to the development and persistence of alcoholism among the elderly. But in qualitative terms, these factors cannot be ignored in treating or preventing alcoholism among the elderly. Primary prevention on the community level could be the promotion of a satisfying social and economic environment for the elderly.

More specifically, at the primary prevention level, the community needs to offer education about alcoholism both to the elderly and to the general public. On the level of secondary prevention (early intervention) the community's task is to supply the means for early diagnosis and casefinding by reaching out to the elderly and not waiting for them to come for services.

Contributing to alcoholism may be the environment in which alcohol is used—the setting is often determined by the cultural patterns of the population. Not enough is known about the drinking habits of the elderly to identify high-risk groups. Extensive and appropriate education, however, is needed at the broadest community level to alert those in contact with the elderly to the signs and symptoms of alcohol abuse and alcoholism, since these are often confused with signs of the aging processes.

Finally there is a need to recognize that the course of an alcoholic's career may be influenced by factors in the general social system other than the consumption of alcohol. Although the etiological factors in the development of alcoholism are not completely known, it is known that if the person's problems are not treated, only greater destruction and despair can ensue. It is imperative, therefore, that the community bring existing health and social welface systems to aid the alcoholic and the family. At the community level, the model requires an evaluation of leaders, informal and formal, who may influence health and social systems or shape policy concerning alcoholism of the elderly.

From Assessment to Action

It is a principle of sound planning that both those who will implement plans and those who will be affected by the implementation should participate in the planning process. In community planning, this principle is all too often violated, and plans are drawn up by merely having the service agencies identify their own priorities and funding needs. This process is carried out independently of consultation with the target population and other service providers. In such a process, it is possible to perpetuate or even expand less relevant services (*17*). It is suggested that service planners commit more time and energy than they usually do to involving a broad range of groups and individuals in planning.

It is advisable to gain support by bringing together representatives of the lay and professional groups that are concerned with issues of alcoholism and with the elderly as well as representatives of the broad-based agency and health delivery systems of the community. A meeting to share information and perspectives can improve the plan greatly and educate the participants.

An assessment of the system of delivering services is useless unless a plan of action is drawn up, program administrators and service providers implement it, funding agencies fund it, and persons with problems use the services. A committee of lay and professional representatives can provide a continuing base of community support. Resources for program development are generally limited and competition for them may be vigorous. It is advisable to secure the investment and commitment of a diverse group of people early in the planning process.

Health care providers are increasingly recognizing the needs of elderly alcoholics and their responsiveness to treatment (*1*). The effective treatment of this group, however, depends on the availability of a network of health and social welfare resources staffed by people who are sensitive to the qualities of being elderly as well as alcoholic. The analytical schema in the model suggest that an effective, comprehensive treatment program must incorporate three interfacing levels of needs —client, agency, and community. Examination of all three levels is necessary to evaluate how they interact and the barriers that they present to effective treatment of the alcoholic.

Strengthening of existing agencies and the establishment of appropriate new ones may be necessary and fundamental to the general goal of helping the elderly alcoholic. However, knowledge of what is needed can only be gained if the present and potential caregivers of the elderly alcoholic make a careful assessment of the existing system. This knowledge is important to those who make policy and give treatment, education, and training, but ultimately it is most important to those currently suffering from problems of alcohol abuse and alcoholism as well as those who will be elderly and alcoholic in the future.

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