SUBSTANCE MISUSE IN THE ELDERLY

RECOMMENDED RESPONSES

FOR CONTINUING CARE

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CLINICAL SERVICES

SUBSTANCE MISUSE IN THE ELDERLY:

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I. EXECUTIVE SUMMARY

In 1988 the number of persons in B.C. over the age of 65 exceeded 380,000 and were responsible for over 40% of the acute care bed days. Some 15% to 20% of those seniors (about 57,000 to 76,000) have a problem with alcohol. As a result, some 27% of elderly acute care bed occupancies are caused by the misuse of alcohol and a significant number more by the inappropriate use of medications. Almost half a million bed days occupied by seniors with alcohol problems is a significant number which will grow dramatically with the growth in the number of seniors and the more dramatic growth in the extent of alcohol misuse amongst this population.

The cost of acute care bed days directly caused by seniors with alcohol problems is currently close to a quarter billion dollars annually. Although it is true that these beds might simply be filled by other patients if the substance misusers did not occupy them, the dramatic growth in demand for these beds, and others, will require costly building programs in the near future. Some 12 to 15 per cent of this demand will be caused by the growth in the numbers of seniors misusing alcohol and medications.

Traditional substance abuse programs have failed dramatically to attract elderly clients by failing to recognize the unique nature of substance misuse in this population and to develop the unique and varied responses needed. This gap in service encourages the client to enter an acute or extended care bed with no resolution of the problem, only to be discharged and repeat the process.

Of the five cities with significant seniors populations in B.C., only one has a seniors specific treatment program in place. VISTA is a Victoria pilot program which is demonstrating success in only three months of operation. For a cost of less than a $1,000. per client, Vista is stabilizing and rehabilitating a large number of clients through it's unique application of a variety of methods and skills. The VISTA program is also developing the necessary assessment and evaluation tools, as well as the policies and procedures which can be replicated in other areas.

I. EXECUTIVE SUMMARY (cont.)

A survey of Continuing Care Programs indicates a definite need for a number of programs like the VISTA program. Long Term Care Case Managers cite their inability to manage substance misusers and the lack of resources for referral. Specialized programs with the ability to commit to long term therapeutic relationships with these clients are urgently required. Only when such programs are in place is there any value in proceeding with any form of training/orientation for LTC staff.

Public attitudes towards the problem are inappropriate and counter-productive. The attitudes of Health Care Professionals toward the elderly substance misuser are no better and contribute to the problem in many cases. Public and professional awareness campaigns can be effective in reshaping attitudes and motivating people to seek help, but only if the treatment programs are in place.

The Seniors Drug Action Program (SDAP) is supporting a number of initiatives designed to reduce the incidence of inappropriate prescribing, dispensing and consumption of medications. The SDAP funding from the Ministry of Labour will expire at the end of fiscal 90/91. These programs need to be supported with messages about alcohol and with on-going therapeutic programs if seniors are to maintain the independence and dignity they desire without exhausting the Health resources to the point of limiting access by younger cohorts.

Substance misuse in the elderly is an problem which impacts on all programs in the Ministry of Health, but most acutely on Hospital Programs, Continuing Care, Pharmacare and Mental Health. These programs must be made to recognize the importance of this in terms of preventable costs and in terms of the needs of the elderly.

The cost of operating treatment programs in the Greater Vancouver, Fraser Valley, Okanagan and Nanaimo areas is $1.76 million. This would provide service to 80% of B.C.'s seniors. The Ministry of Health should approach The Ministry of Labour through the Inter-ministerial Committee on Substance Abuse Programs, (ICSAP), with a coordinated plan to fund, deliver and monitor prevention and treatment programs for seniors.

SUSTANCE MISUSE IN THE ELDERLY

RECOMMENDED RESPONSES

II. THE POPULATION

British Columbia is experiencing a significant demographic redistribution to a more elderly population. This population shift requires a parallel shift in the types of services to be delivered in the future. It also requires a shift in thinking which is not conditioned by previous experience and knowledge.

In 1991 the number of persons over the age of 65 years in British Columbia will exceed 800,000 and they will come to represent some 14% of the population within the following 15 years. The growth in this segment of the population is congruent with the growth in the consumption of health care services because of a natural increase in usage rates of medical services, such as acute care beds, as people age. People over the age of 65 use over 40% of the acute care hospital bed days while youth (10 - 19) use some 10%. Knowledge of any factors which contribute to greater usage are of compelling importance and need to be addressed.

The pressure on acute care beds has stimulated research into better ways to meet the health care needs of an aging population. Dr. Duncan Robertson's paper on bed blockers and the subsequent successful pilot of the "Quick Response Team" are clear examples of the new initiatives needed to meet the demands for care. Similar kinds of research have begun to indicate the extent to which misuse of medications and alcohol are primary causes of admissions to acute care hospitals. The Chemical Dependency Resource Team was piloted in Victoria to identify, and intervene with, patients admitted to acute care hospital beds because of alcohol abuse. Some 65% of their cases were seniors and 27% of all seniors admitted were diagnosed as having an alcohol problem.

The elderly have not, until recently, been the preferred subject of researchers. Our knowledge of the differences in this population's needs and the extent to which traditional programs might meet those needs, has been inadequate for proper planning. As the population shift begins to create new demands for service it becomes clear that there are serious implications for program planning and resource allocation within Continuing Care as well as amongst Hospital programs and other services. Increasingly it proves worth expending more dollars to maintain seniors in independent living arrangements and reducing the expenditures (or the growth in expenditures) on facilities.

III. THE PROBLEM

Traditionally, two of the least desirable fields of study in health care have been substance abuse and the elderly. In combination they constitute the 'no mans land' of clinical practice and research. As late as 1973 the Rutgers University Center of Alcohol Studies could state "The chances of a person over 55 years of age being an alcoholic in the clinical sense of the word are minimal." This lack of research into a problem characterized by denial, with symptoms masked by the aging process itself, and clients isolated from the work, social and family contacts typically used to identify younger cohorts, has led to a public denial of the existence of substance abuse problems in the elderly. The lack of specialized resources for elderly misusers and the lack of training of health professionals in the identification, treatment and referral of substance misusers has further limited understanding and awareness of the extent of the problem. Physicians seldom identify alcohol or drug misuse in their patients and indeed, bear some responsibility for much of the medication misuse.

The public denigration of the elderly as having little social worth finds common expression in the oft heard opinion "let them drink, it's their only pleasure." No other group in society is referred to in this way; not native people, nor women, nor youths. Only the elderly are deemed so worthless as to be urged to continue such destructive behaviour. The sum of all the above conditions is that the elderly have been ignored by those responsible for substance abuse treatment and the substance abuser has been ignored by those responsible for care of the elderly.

IV. THE EXTENT

In the past ten years some significant work has been done in exploring the nature of substance misuse in the elderly. Alcohol and Drug Programs commissioned four reports on the extent, nature and required responses. The indications from these reports and those of other jurisdictions are: that the extent of substance abuse in the elderly exceeds common expectations; that the costs to hospital, continuing care and other health care programs is extensive; that the elderly require specialized treatment responses which are significantly different from existing resources; and that there are at least two different and clearly identifiable types of substance misuser in the population who respond differently to the traditional approaches and have a quite different prognosis.

IV. THE EXTENT cont.

A 1979 study by S.P.A.R.C., Problem Drinking In The Older Person, Parsloe and Sakowicz, surveyed nine care facilities in Vancouver and concluded that there was a significant problem in that 51% of the residents were drinking to excess. Homemaking agencies reported that 13.7% of their caseload drink to excess. The same study reported that a survey of housing developments for seniors estimated 22.1% of their tenants were problem drinkers.

A 1985 report by Kathryn Friesen, Seniors With Alcohol And Drug Related Problems in British Columbia: Assessing & Planning for Their Needs, estimated that between 4.5 and 10%, (16,000-37,000), of B.C.s seniors' over the age of 65 have alcohol related problems. Friesen noted that only 0.1% of the province's seniors used Alcohol and Drug Services and, according to (conservative) prevalence estimates of seniors experiencing drug and alcohol problems, only 5% of those with problems used provincial programs. Most of these were in one Vancouver detoxification center. Friesen went on to identify three categories of seniors with alcohol problems: Elderly who avoided alcohol and drug problems as younger adults but who are at risk due to a variety of factors related to the aging process; Late Onset problem drinkers, whose substance abuse is a reaction to the aging process; Early Onset or chronic alcohol abusers who have survived into old age despite their addiction and who are familiar with treatment agencies.

A 1986 report by Rowe and Associates, An Investigation Of Program Models For the Elderly Alcohol Abuser, described two programs which were having some success with older alcohol abusers and looked at several other alternative programs.

In 1986 ADP requested a review of the literature on alcohol and drug misuse in the elderly which resulted in the Ministry's report, Substance Misuse In The Elderly. Phillion, Sept. 1988. The first part of this report (on medications) was completed in April '88, and catalysed interest in a number of people who set up an ad hoc committee to look into responses to the problems of medication misuse in the elderly. The Ministry of Labour responded by funding The Ministry of Health to set up the Seniors Drug Action Program.

The second part of the report concluded that the exact rate of alcohol misuse amongst B.C. seniors was unknown, but that it could conservatively be estimated at some 15-20% of the over 65 population (57,105-76,140 persons). The report went on to note that B.C. has the highest percentage of current drinkers in Canada and that the number of current drinkers has continued to grow over the last several generations.

V. THE CONSEQUENCES

The fact that few seniors who misuse alcohol are likely to utilize existing Alcohol and Drug Program resources has tremendous implications for the Ministry of Health. Alcohol abusers over the age of 65 are more likely to be admitted to an acute care hospital because of a greater tendency to medical problems including: heart and circulatory disease, liver cirrhosis, gastrointestinal disease, cancer of the throat and larynx, fractures, seizures, alcohol diabetes, malnutrition, poly-neuropathy, Wernicke-Korsakoff Syndrome, dementia and cerebellar degeneration.

Programs implemented in hospitals in Victoria and Winnipeg suggest that 27% of seniors admitted to acute care hospitals are admitted because of alcohol abuse (even higher if medications are included). If these numbers are accurate then alcohol abuse is responsible for some 494,176 hospital bed days annually in British Columbia at a cost of $222,379,384.50. This figure does not include the cost of caring for those whose medical conditions may have been more subtly impaired by alcohol consumption at a lower and undiagnosed rate. Nor does it include the cost of premature entry into extended care beds, LTC beds, psychiatric beds or other facilities. In addition there are significant numbers of seniors having adverse reactions or suffering physical and mental degeneration due to inappropriate use of medications.

VI. PREVIOUS RECOMMENDATIONS

The reports mentioned above have made a number of recommendations which have not been acted on. Parsloe and Sakowicz (1979) recommended that the Ministry of Health direct the (then) Alcohol and Drug Commission and the (then) Long Term Care Program," to initiate a joint effort in research, assessment, appropriate referral and rehabilitation of those persons aged 60 and over who have alcohol related problems, ie: alcoholism or habitual or episodic excessive alcohol consumption."

More specifically the authors recommended that "the ADC and LTC design and implement a concise, standardized alcohol assessment checklist which may be used by provincial and municipal health assessors", (sic); that the Ministry initiate a pilot project to establish an alcoholism rehabilitation program for the over 60 population; and that the Ministry initiate a pilot project for a community based outreach program, employing a team of workers who would provide casefinding, problem identification, crisis intervention, consultation to primary care-givers, follow-up, data collection and program evaluation in relation to alcohol interrelated services to the over sixty

VI. PREVIOUS RECOMMENDATIONS cont.

Friesen, 1985, made a series of recommendations on "Primary prevention for the entire population as well as high risk groups; Secondary prevention for aging adults with new alcohol and drug problems; (and) Tertiary prevention for aging adults with chronic alcohol and drug related problems.

Friesen looked at the contemporary senior's programs of her day and recommended that they be expanded, enhanced with outreach and aftercare components and implemented in areas of high risk population concentrations. She also recommended that more volunteer programs (such as seniors peer counsellors) be developed to provide support to these programs and that innovative programs such as controlled drinking be offered to seniors. Friesen went on to recommend that there be more active support from ADP for Peer Counselling Groups, an increase in support for prevention projects aimed at seniors wellness and mass media campaigns on the issues of aging and stressing the importance of moderating drinking practices in adults.

For the elderly with chronic alcohol and drug problems she recommended that ADP participate with Mental Health Services Psychogeriatric teams and collaborate with MHS and Continuing Care in developing a comprehensive system of services to seniors. Friesen also recommended that ADP designate some of its agencies as centres for the aging adult. Friesen concluded that unless seniors with alcohol and drug problems are helped they will use up resources to such an extent as to reduce access to health care for the young.

Rowe and Joy (1986), noting that substance abuse rarely occurred in isolation from the other stresses of aging, recommended a wholistic approach to treatment of the elderly. They called for a standardized assessment instrument, an aggressive marketing campaign to encourage referrals and stigmatize over-consumption. Finally they recommended that outreach services be developed and that a variety of treatment services be available in one facility.

VII. CURRENT RESOURCES

There are currently few ADP resources dedicated to the treatment of seniors with substance abuse problems, and only one exclusive service, the VISTA program in Victoria. There are two outpatient clinics which offer specific seniors components with their mainstream programs: the Nanaimo clinic, a direct service which is being phased out, and the West End clinic in Vancouver. In addition to these a number of clinics (Vancouver, Duncan, Kelowna) have one of their counsellors designated as the seniors specialist. These specialists have no specific training in gerontology or in care of the elderly. The Central City Mission in Vancouver also deals with a number of seniors but focuses on the chronic abuser. ADP has offered to fund two social work positions at Shaughnessy hospital as elderly outreach counsellors but no coordination was planned with Vancouver Health Department's LTC services.

The VISTA (Victoria Innovative Seniors Treatment Agency) is the only wholly seniors specific treatment service for substance abuse in the province. It is a pilot project to develop a model for other areas. Vista is unique in North America in being located in a seniors facility and in being the coordinator of a whole range of service needs in treating the elderly substance abuser. A special arrangement with the Capital Regional Districts' LTC Program allows VISTA clients to be declared LTC eligible if they need to enter the residential treatment program or require support such as homecare nursing, homemakers, OT, PT or any other services. At the same time, Vista itself is intended to offer a variety of treatment approaches to suit the needs of individual clients who are quite different from younger clients and, differ widely amongst themselves. Outreach counselling services, linked closely to LTC assessors take the program to the senior and allow for long term intensive therapeutic relationships to be developed. As VISTA develops it will offer day programs, residential treatment, minimal risk drinking, home detox and extensive follow-up and resocialization. The staff have backgrounds in psychiatric nursing,social work, and psychology. They are supported by a sessional physician and part time nutritionist.

The question of whether there is a need for these services has been answered quite dramatically by VISTA, as it has accepted over 125 referrals in it's first three months of operation. There is no doubt that they will meet their predicted first year case load of 300 clients without even seeking out the hidden population which is intended to be one of their primary targets. The cost per client is forecast to be in the $1,000. range, or 2.5 bed days.

VIII. NEEDS

In addition to the material obtained from the above mentioned studies, several Long Term Care programs were surveyed informally in order to obtain some sense of the perceived needs of those people working in the field. The overwhelming majority of responses was for some form of clinical support, specifically for treatment programs which could take responsibility for the clients who are not amenable to normal Long Term Care services but require specific therapy for their substance misuse problems.

It would not be an exaggeration to say that there are hundreds and even thousands of elderly clients of the LTC system in the major centres of the province who are in need of alcohol and/or drug therapy and who are not able, or not willing to access existing services. These clients are responsible for millions of dollars in acute care hospital costs as well as thousands of hours of home care services and other community resources. They are more liable to use every component of the health care system than those who are not misusing substances, and represent not only a major drain on health care resources, but a source of frustration for those who attempt to deal with them without the required professional resources and skills. In addition these citizens are not receiving the kind of care they need to maintain their independence and quality of life.

There is a demonstrable need for specialized elderly substance abuse treatment services in every part of the province and there is a critical need in those centres with major seniors populations. The only centre with such a service at this time is Victoria. Funding is urgently needed for similar services in Greater Vancouver, Okanagan Valley, Fraser Valley and Nanaimo. In addition, other more flexible programs, adapted to different demographic realities, are required in each of the regions to provide some equality of access to service. Beyond the obvious need for treatment services, there are needs for standardized substance abuse assessment instruments which are relevant for the elderly client, program standards for seniors treatment and also for evaluation designs which specifically measure the effectiveness of programs for the elderly. There is also a need for prevention, education, caregiver awareness and training programs.

IX. RESPONSE

Treatment Programs: The Model.

Experience is demonstrating that the preferred model is of a multi-disciplinary treatment team operated by a funded non-profit society preferably located in an LTC facility with close links to and liaison with the local LTC assessors. The facility would preferably have a few personal care beds which can be designated as respite beds for the purposes of the residential part of the program. There should be a management committee with representation from the local long term care administrator, the facility and the funded agency. It is vital to ensure smooth access to service between the treatment program and Long Term and home nursing care. There should also be a community advisory board with representation from other community services, such as; Hospital, Mental Health, Alcohol and Drug, etc.

The counsellors, coordinator and support staff can all be hired on personal service contracts by the funded agency which simplifies their bookkeeping and allows for greater flexibility in program management. Thus the figures quoted for staffing the programs are inclusive of all benefits and other costs. The recommended plan is to develop service units of sufficient size to support a number of counsellors of mixed training and experience, always focusing on counsellors with a sympathetic understanding of the elderly.

The treatment program must emphasize outreach and provide counselling services in the clients home, particularly where an LTC assessor requests service. In addition the program should provide day programming, residential programs, educational/prevention services and extensive resocialization and follow-up. The older client requires more intensive and longer term support than younger clients.

There appears to be justification for a staff to population ratio of one counsellor for every 10,000 persons over 65. In addition to the counsellors, coordinators and support staff, the programs require some medical sessions and some access to nutritionists, O.T.s, P.T.s and home support.

The 1988 population estimates for B.C. cite a population of 380,700 persons over the age of 65. By developing VISTA like programs in the areas which can be most effectively serviced by the model, some 304,520 seniors or 80% of the total would have access to the services. The four service areas are: Greater Vancouver/North Shore, the Fraser Valley, Okanagan Valley and Cowichan/Nanaimo/Qualicum.

X. TREATMENT PROGRAMS: THE COSTS

Vancouver: (including outreach to Burnaby, Richmond, North Shore and New Westminster.) >65 pop. 125,926

One coordinator on inclusive contract.....	$ 45,000.00	
twelve counsellors at 36,000.000.....	432,000.00	
clerical support 3 at 24,327.....	72,981.00	
.5 nutritionist	19,500.00	
	$569,481.00	$569,481.00
Medical sessions (5 per week)..... (2 for Van. 1 ea. for the rest)	58,630.00	
	58,630.00	$628,111.00
Space rental (est. 4 rms. at 6,000.)	24,000.00	
Travel for 13 staff times 300. per. mo.	42,200.00	
Office supplies	3,000.00	
Books and printing	5,000.00	
Advertising	2,500.00	
Postage	500.00	
Phone	3,000.00	
Insurance	500.00	
Audit	500.00	
Staff/Community development	7,000.00	
Recreation/catering.....	7,000.00	
Evaluation	5,000.00	
	$100,000.00	$728,111.00
Administration fee @5%.....	36,405.55	
	36,405.00	$764,516.00

START-UP COSTS:

Furniture	13,500.00	
Computer/wp	9,500.00	
Orientation/placement at VISTA	3,500.00	
	26,500.00	$791,016.00

TREATMENT

Operating costs (cont.)

Nanaimo: (including the area Cowichan to Qualicum) >65 pop. 25,201

One coordinator on inclusive contract	$ 41,000.00	
2.5 counsellors at 36,000.	90,000.00	
One clerical support at 24,327	24,327.00	
.2 nutritionist	7,800.00	
	163,127.00	$163,127.00
Medical sessions 1 per week	11,726.00	
	11,726.00	$174,853.00
Space rental est. 2 rooms at 6,000.	12,000.00	
Travel for 3.5 staff times 500 per mo.	21,000.00	
Office supplies	2,000.00	
Books and Printing	4,000.00	
Advertising	2,000.00	
Postage	300.00	
Phone	2,000.00	
Insurance	500.00	
Audit	500.00	
Staff/Community development	2,500.00	
Recreation/catering	2,000.00	
Evaluation	2,500.00	
	$ 51,300.00	$226,153.00
Administration fee at 5%	11,307.00	
	$ 11,307.00	$237,560.00

Start-up Costs:

Furniture	4,000.00	
Computer	7,500.00	
Orientation/placement at VISTA	1,000.00	
	$12,500.00	$249,060.00

TREATMENT

Operating Costs (cont.)

Fraser Valley Region (>65 pop. 67,876):

One coordinator on inclusive contract	$ 45,000.00	
6.5 counsellors at 36,000.00	234,000.00	
clerical support 2 at 24,327.	48,654.00	
.2 nutritionist	7,800.00	
	$334,654.00	$334,654.00
Medical sessions (3 per wk.)	35,178.00	
	35,178.00	$369,832.00
Space rental (est. 3 rooms at 6,000.)	18,000.00	
Travel for 7.5 times 400 per mo.	30,000.00	
Office supplies	2,500.00	
Books and printing	4,000.00	
Advertising	2,000.00	
Postage	400.00	
Phone	2,500.00	
Insurance	500.00	
Audit	500.00	
Staff/Community development	5,000.00	
Recreation/catering	5,000.00	
Evaluation	2,500.00	
	72,900.00	$442,732.00
Administration fee @5%	22,136.00	
	22,136.00	$469,868.00

START-UP COSTS:

Furniture	6,500.00	
Computer/wp	9,000.00	
Orientation/placement at VISTA	2,500.00	
	18,000.00	$482,868.00

TREATMENT

Operating Costs (cont.):

Okanagan Valley (including Penticton to Vernon) .65 pop. 35,555:

One coordinator on inclusive contract	$ 45,000.00	
3.5 counsellors at 36,000.00	126,000.00	
clerical support 1 at 24,327.	24,327.00	
.2 nutritionist	7,800.00	
	$202,327.00	$202,327.00
Medical sessions (3 per wk.)	35,178.00	
	35,178.00	$237,505.00
Space rental (est. 2 rooms at 6,000.)	12,000.00	
Travel for 3.5 times 400 per mo.	16,800.00	
Office supplies	2,000.00	
Books and printing	3,000.00	
Advertising	2,000.00	
Postage	400.00	
Phone	2,000.00	
Insurance	500.00	
Audit	500.00	
Staff/Community development	4,000.00	
Recreation/catering	4,000.00	
Evaluation	2,500.00	
	48,900.00	$286,405.00
Administration fee @5%	14,320.00	
	14,320.00	$300,725.00

START-UP COSTS:

Furniture	4,000.00	
Computer/wp	7,500.00	
Orientation/placement at VISTA	2,500.00	
	14,000.00	$314,868.00

X. TREATMENT

The total budgetary requirements for the start up and operating costs of providing a treatment service for elderly substance misusers is $1.76 million.

The program needs of these services in terms of treatment models, policies and procedures, intake/assessment documents, evaluation designs, data collection forms, etc., can be acquired from those developed by the pilot program VISTA. The data collection software can be transferred to any new program with an IBM compatible PC.

XI. PREVENTION

Inappropriate public attitudes to substance misuse in the elderly have already been described as has the older persons reluctance to admit to problems or to view substance abuse as a health issue. The needs of professionals and their attitudes to this population have also been described.

Much of the need for greater public and professional awareness of medication misuse is, or will be, met by the programs being developed by the Seniors Drug Action Program (SDAP) which is already funded by the Ministry of Labour. Coordinated advertising with the TRY campaign will heighten public and professional awareness of the need for safer practices and more communication between professionals and clients.

In addition to the awareness campaigns, SDAP will pilot a number of initiatives designed to increase professional competence, caregiver initiative and patient compliance.

Some similar initiatives are needed on the issue of alcohol misuse in the elderly. Specific public awareness messages targeting the elderly consumer, caregivers and health care professionals are necessary to overcome the current inappropriate public response to this problem and stimulate action. The "hard nosed" public messages aimed at the general population do not appeal to the elderly or to their caregivers any more than do the traditional treatment programs.

XI. PREVENTION

The surprising extent of the alcohol problem in the current population of elderly will likely be surpassed by future cohorts as they mature, since they will come from generations with higher numbers of drinkers and drinkers who were used to consuming larger amounts of alcohol. The combination of dramatically increased numbers of elderly and a higher proportion of them with a history of heavy alcohol use could, if not addressed, create such pressures on the Hospital and Continuing Care Programs that younger patients will suffer severely diminished access to health services. The treatment programs described above are essential to any reduction of the demand for services by this population, but no amount of treatment, in isolation, can stem the coming tide of elderly people with alcohol problems.

It will be necessary to dramatically change the way in which people view the aging process and its' implications for consumption of alcohol and medications. The first step is an advertising campaign which stimulates public awareness of the problem, encourages people to seek help and communicates the message that a successful resolution is not only possible but likely. The first year of this campaign will require some $200,000. for design work and promotion and should be coordinated with the Ministry of Labour's TRY campaign for maximum impact.

XII. STRATEGY

In order to implement the required programs, it is recommended:

that Hospital Programs,Pharmacare, and Family and Community Services be encouraged to support the above initiatives and develop an overall prevention treatment policy for seniors consistent with other initiatives to maintain senior's independence;

that The Ministry of Health take immediate steps to negotiate with the Ministry of Labour and Consumer Services for the provision of funding for seniors substance abuse treatment services, similar to that available in Victoria, in the four major seniors population centres in the province by presenting a plan to the Interministerial Committee on Substance Abuse Planning (ICSAP);

XII. STRATEGY (cont.)

that (if The Ministry of Labour and Consumer Services will not respond with a comprehensive plan for providing the needed resources on a provincial basis,) Continuing Care and Hospital Programs develop a plan to fund treatment services in fiscal 1990/91. Prevention programming should be negotiated with Community and Family Services.