

Isle of Man

Alcohol
Advisory
Service

Annual Report
2006/07

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Directors Report 2006/2007

Welcome to the annual report for the year ending March 2007 and what an eventful year for the service it has been with many exciting achievements.

We begin this year with the news of the Comic Relief grant to fund a dedicated young person's worker. As many of our supporters know, we have campaigned for government funding for a number of years to employ a dedicated worker to deliver this work. The rationale behind this post has always been evidenced, based and centred on best practice in working with affected young people, as young people on the IOM have some of the highest levels of alcohol consumption and problems from alcohol use in Europe.

As this funding was never forthcoming, the AAS made a bid to Comic Relief and following a rigorous assessment process they appreciated the need for this provision and awarded us funding of £120,000 for the next three years to develop this dedicated outreach service.

What is particularly unique about this post is the support for young people who live with parental problem drinking.

We are also delighted that current staff member Jenny Fong has been successful in securing this position and she is conducting a consultation with all potential referrers and young people on how this service should best be developed.

We are grateful to the young people involved in our Alcohol Peer Education project who voluntarily gave up their time to meet with the assessor and convey their thoughts on teen alcohol problems on the IOM. Thanks also to Michael Taylor, (committee Member) who gave an account of his experiences of teen drinking in his role as a detached youth worker for the Department of Education.



Members of the Peer Education Group celebrating the news about the Comic Relief Grant

Client numbers continue to increase annually with no slow down in demand. A total of 654 clients made contact with the service and a mammoth 2821 support & counselling sessions were conducted. The likelihood of us continuing to meet this demand is unlikely to continue due to the loss of Jenny's part-time post within normal services.

The last financial year saw a deficit in funding from the DHSS with a shortfall in the budget of approximately £15,500. Although we were able to buffer this with our reserve fund, we knew that this 07/08 funding was not going to meet basic running costs. Thus cutting a part-time post has been our only option. This, of course, has a knock on effect in service delivery.

Aspects of service delivery which have been affected are:

- extending the time limit for an initial assessment appointment to 5 working days
- a reduction in home visits.

Some services have been withdrawn and the decision to do this was not taken lightly - one casualty being the work we do for Probation. This work is often challenging as clients are frequently attending under duress following involvement with the Criminal Justice system. We are currently in discussions with the Department of Home Affairs with the hope that they will be interested in developing a separate

service level agreement for this work. For the time being, until staffing levels increase, we have had no choice but to withdraw this service.

This service is not alone in facing reduced funding and many other charities in the voluntary sector have also felt the pinch whilst the DHSS attempts to reign in its spending. Many organisations in the voluntary sector though provide a substantial amount of social care provision on the island and the squeeze will ultimately impact on those most in need. Often organisations in our sector provide a service at a lesser cost than statutory services, so the economics of under-funding this sector are debatable.

One positive consequence of the funding situation has been the formation of a new fund-raising committee. A number of events have been held this year and the service raised more charitable funds than ever before. You can read the enclosed report on their first year's achievements and other initiatives that are generating monies, including financially contracted education and training work. The service has had to become entrepreneurial in marketing its education and training programme.



Minister for Education Anne Craine MHK, IOM College Principal Ian Killip, and Anne Gundry, head of student services attempt the Board game 'wasted' designed by Jenny Fong of the AAS at the IOM College Health Fayre March 2007

The above achievements would not be possible without the dedication of the staff who have diligently gone beyond the call of duty to keep to the service standards and still maintain high standards of client care. The expertise and qualifications that the staff have amassed between them show them to be some of the most qualified in the Island's addiction field and they have been incredibly loyal to the service in these difficult times, when salaries have been frozen and training opportunities reduced.

The Alcohol Peer Education Project - a joint effort set up between Ballakermeen High School, the IOM College and Peel Youth Club has been running throughout this year under Kay's guidance and we consider this activity to be one of our most successful youth projects to-date. There are plans for this group of young people to continue working together with the formation of an alcohol youth forum and you can read all about this initiative in this year's report.

Our education programme for offenders in the prison was successfully re-established through a link with the Dept of Education. The link between leaving prison and contact with the community has now been re-established. The service has conducted more alcohol awareness group sessions in this last 12 months than in previous years, and has also been paid to conduct this work. An evaluation of these groups, which is most favourable, is contained within this report.

There are also two other reports on special projects completed by staff namely, the Alcohol and the Elderly Workshops, by Debbie Doyle and the Foetal Alcohol Spectrum Disorder awareness project, by Jenny Fong.

Another major achievement has been the service involvement in the development of the 'National implementation plan for supporting significant others affected by substance misuse on the IOM'. This document has been produced by Professor Richard Velleman and his team at the Research & Development Unit at the University of Bath.

Richard who is a prolific author and world renowned figure in promoting family interventions first became associated with this service as a speaker to celebrate our 25th anniversary. Another guest at this event was

the Carer's Co-ordinator David Gawne MBE, who linked up with the service in the following year for the carer's conference in 2005 when Richard was the keynote speaker. His presentation, coupled with our service user's stories on living with a problem drinker in the family, proved very moving and fortuitous, in that the impact made on the audience enabled us to secure funding for the plan to be drawn up and to form a Family Working Group to oversee this process. This document has also been able to make use of the GENACIS research.

The GENACIS study conducted in 2005 surveyed 1000 Manx residents on a range of subjects related to alcohol consumption, health and lifestyle. Much scientific data was accumulated from this research including experiences of problem drinking in the family. This research reported that up to a quarter of the Island's population, (20,000 individuals) have been affected by a relatives drinking.

We believe that this research alone justifies the AAS's existence and its long standing approach to offering family members/significant others a service in their own right.

Our work with families is underestimated as a social intervention on the Island and if we were able to employ more staff we could probably do so much more. Although many believe there is little that can be done, much success can be achieved with family members by working on increasing resilience and altering family dynamics. There is even some research that states working with the family members alone delivers more success for the problem drinker in a family, even if they never attend a treatment service.

Both the GENACIS research and the Implementation Plan for families & significant others have been useful in showing us where the priority areas of future work are for the AAS and unquestionably, have put this service on the international addiction field map.

This research though does bring into question the approaches that we have in relation to alcohol problems not just in the Isle of Man, but in the addiction field overall.

The Island's response to alcohol problems this past 10 years has seen the predominance of a medical/detox model for dependent drinkers and early social intervention approaches have not been appreciated to the same extent. This model is too individualistic and lacks support for the spectrum of alcohol problems experienced in the population and the many family members that GENACIS shows are great in number.

The now widely accepted model of alcohol problems lists the following classifications: severely dependent, moderately dependent, through to harmful and hazardous drinkers. The latter problem drinking client groups are far greater in number and research shows if they access services in the earlier stages, a successful treatment outcome is more likely.

It is worth noting that we are currently the only service that offers help for the complete spectrum with a variety of approaches. From brief advice, support and case co-ordination and also more skilled counselling and addiction interventions. This can involve early intervention/controlled drinking/ harm reduction approaches through to preparation for detox. It also involves harm reduction strategies for severely dependent drinkers who are unable to abstain and relapse prevention for successful abstainers.

Our outcomes programme included within is the newly adapted outcomes spider from Alcohol Concern. This programme is being used throughout the UK and demonstrates the holistic benefits of our alcohol treatment interventions.

Looking at topical issues around alcohol. Increased population consumption and concern in health issues is hitting the headlines. An analysis of mortality statistics for the UK shows that the death rate from alcohol defined conditions, mainly liver disease, virtually doubled between 1991 and 2004. The link between high blood pressure and soaring obesity rates is also being linked to increased consumption in the general population.

The costs now and in the future to the public purse for the health of the nation are arguably outweighing the original public disorder concerns and rationale behind 24 hour licensing. It was hoped that liberalisation would help us to adopt relaxed continental style drinking habits, but some quarters argue it's going to take more than an act of Parliament to achieve this cultural shift. How we reverse these trends coupled with ever increasing concerns surrounding alcohol fuelled anti-social behaviour, has prompted a review by Gordon Brown into the impact of relaxation of the licensing laws in 2005 as he states,

"The change in the law has prompted very strong views and it is right to look at the evidence".

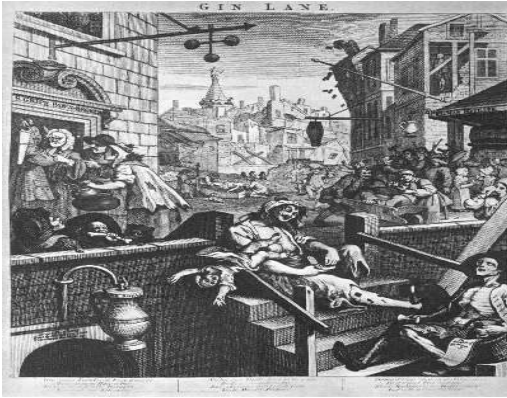
It is almost universally accepted that strategies aimed at prohibition of alcohol are not viable, but going too far the other way has inadvertently conveyed the wrong psychological message to the nation.

Historically we have a complex relationship with alcohol which will certainly need a multifaceted response if social change is to be achieved. The likelihood of this happening would appear to be in the distant future as alcohol is viewed as the lesser problem, with investment being ploughed into tackling illegal drugs through enforcement, the police, customs and drug treatment medical services. The very nature of illicit drug use simplifies society's response to control it and politically 'a war on drugs' is always a vote winner.

Paradoxically, we are going through an especially liberal period in history towards alcohol and its use has never been more tolerated with 90% of the population indulging regularly. This coupled with a self-regulated drinks industry, which spends more on advertising than the alcohol treatment field receives in government funding per annum.

On the darker side of this cultural acceptance, there are estimates of 1.2 and possibly 2.5 million children, living with parental problem drinking in the UK alone. Indeed, some commentators have made modern day

comparisons to Hogarth's *Gin Lane* in drawing attention to the social and familial impact of alcohol-misuse facing modern day society.



The British Government has made some efforts to begin this process with the publication and update on its alcohol strategy, "Safe sensible and Social - the next steps in the National Alcohol Strategy".

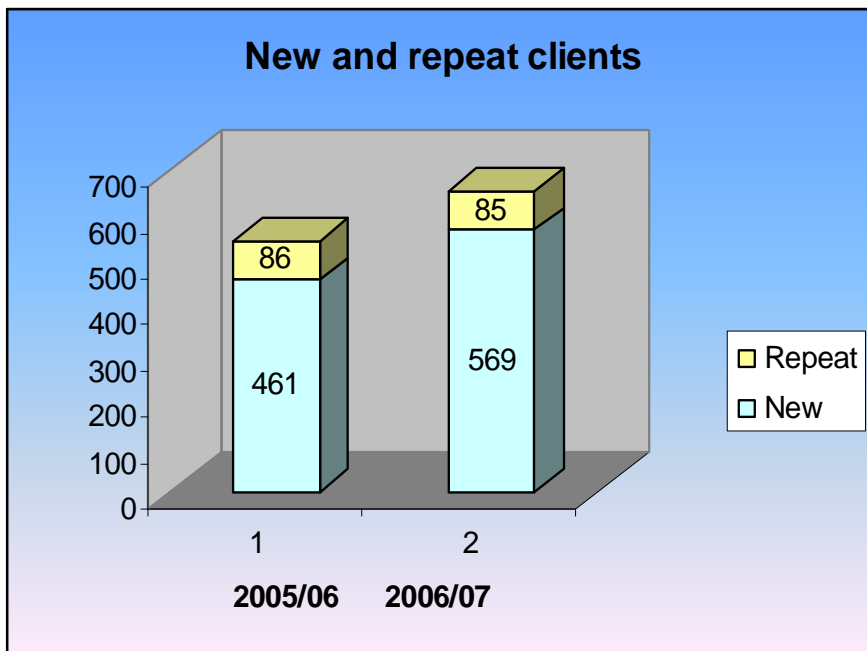
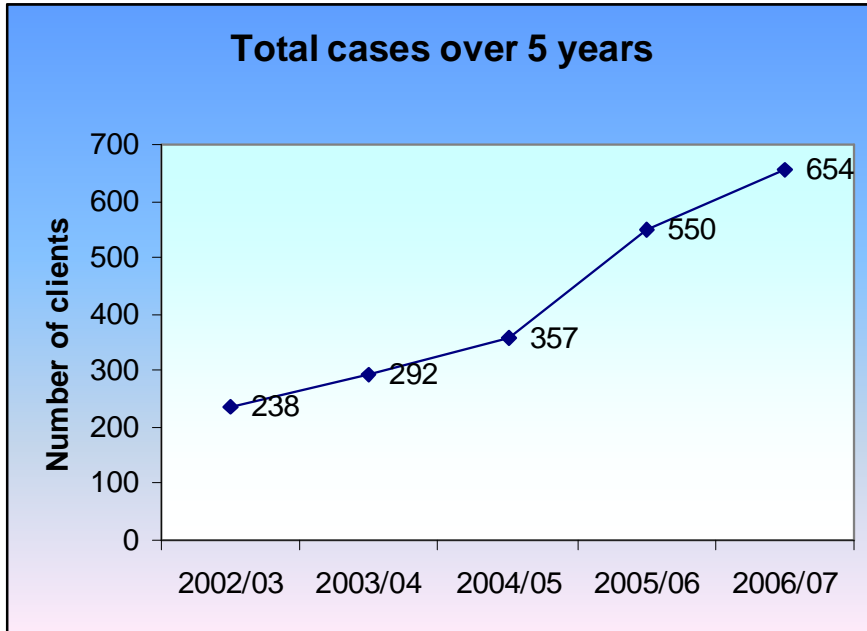
Recommendations in this report include the acknowledgement that an alcohol policy should not just be about supporting dependent drinkers but others within the spectrum of alcohol problems and the directive to the previously unencumbered drinks industry, that units should be displayed on all cans and bottles amongst other tightening up measures.

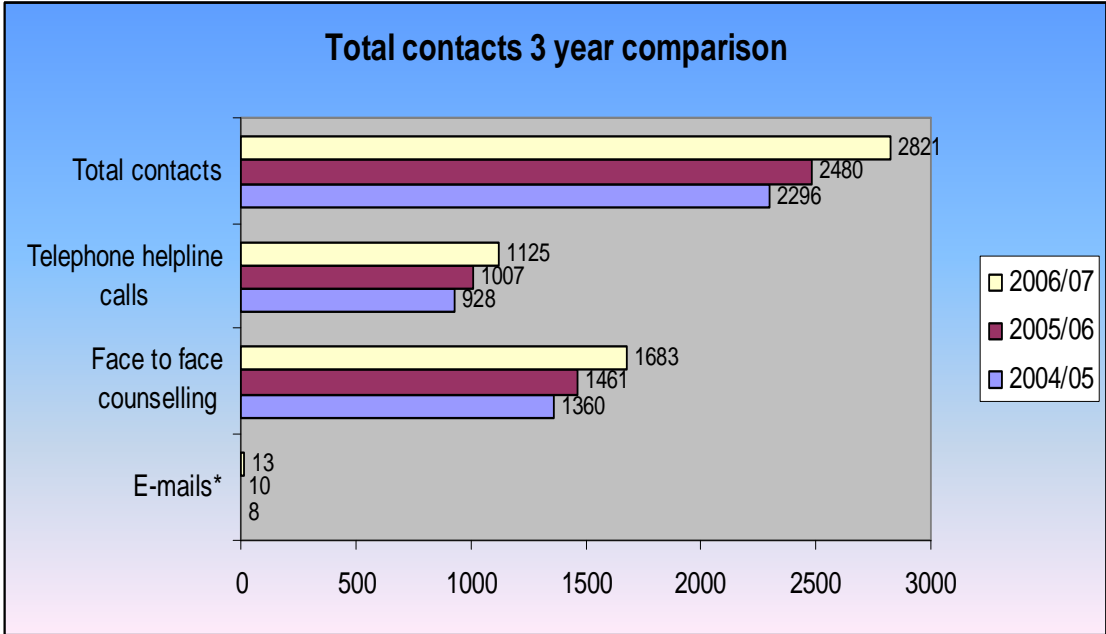
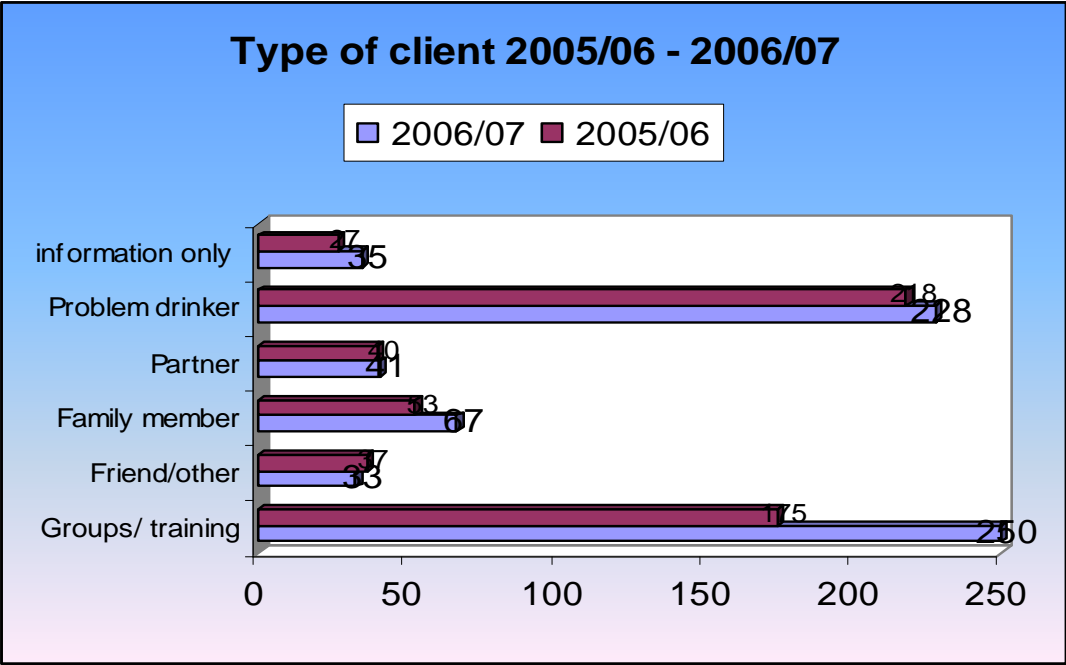
And finally.....

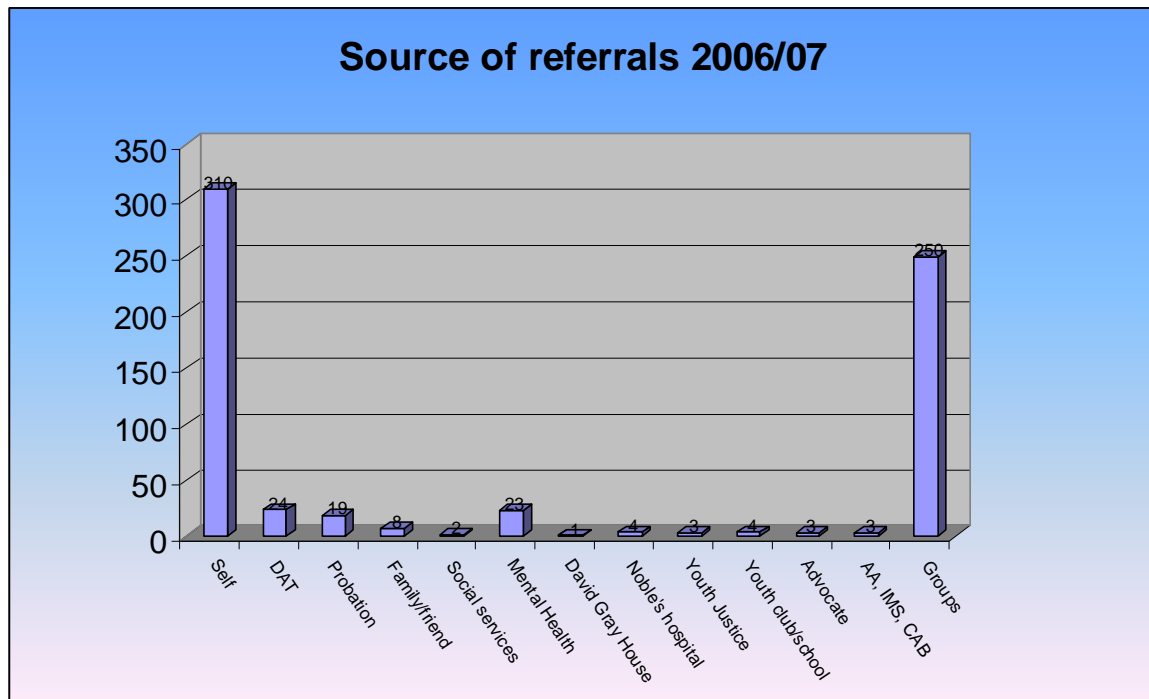
The service has thus far in the face of the funding crises continued to offer a quality service and the challenge for the immediate future is how we continue to do this whilst funding from the DHSS has been frozen for 2007/08. As a supporter of this service reading this report there are a number of things you can do to help, support us by passing on the word to friends and colleagues the details of planned fund-raising events, or, pass this report around to local members of your community in order to raise the profile of the valuable work of the service. Lastly, thank you to the committee members and officers of the service, who have supported us during this enjoyable, but at times challenging year. This has been greatly appreciated by all staff and let's hope we can continue to strive to meet the demand for our services which sadly never seem to decline.

Thea Ozenturk September 2007

Client data April 2006 to March 2007







Comments and trends

The five year comparison chart shows 2006/07 to have been our busiest year to date with a total of 654 new and repeat referrals and an epic 2821 contacts with 1683 of those being counselling and support sessions. This is a major feat considering the staff to client ratio but, as previously mentioned, this growth will not continue with the loss of a post in the next financial year.

Also of interest is the steady amount of repeat clients which appears to increase slightly year on year. These clients are often individuals who may have relapsed following a period of abstinence or stabilisation or significant others, who have concerns about a family members return to drinking.

Self referrals continue to be the main route into the service, the majority of clients reporting to find us through the local phonebook and in comparison, referrals from outside agencies are still disappointing.

This past 12 months as a way of improving referrals from statutory agencies we put a good deal of thought and effort into creating and marketing a referral pack. This was sent out to all potential referring bodies in the hope that we could improve links and thus

increase referrals. This also helped us to meet one of our own self improvement targets from the recommendations of the Commission of Inquiry.

Alas, this has not proved very useful with only a handful of referral forms being utilised. Possible reasons for this include potential referrers not being aware that at the root of a family's or individual's difficulties is an alcohol problem or they prefer to send clients to statutory services with the old view that voluntary or non-statutory services provide a less specialised response. There may be other reasons but either way this remains an area of disappointing performance and will only improve when the value of an integrated referral pathway for all potential clients is put in place.

In the mean time, another route that we have explored as a potential referral booster is our specialised substance misuse training programme. The last few years has seen growing interest in the work of the service in the social care field and we have been asked to provide training in specialist areas such as: foetal alcohol spectrum disorder; drug awareness sessions for teachers and students; effective working with the children of problem drinkers; detainees at the IOM prison and alcohol and workplace training for the corporate field. Following on from a training initiative, agencies refer to the service and links improve dramatically and this does seem to be the way forward.

Alas though, the dilemma we face is if we increase demand from outside agencies and the referral rate, will we be able to meet it with our current staffing levels.

Outcomes 2006/2007

Introduction

Outcome measures have become increasingly important for voluntary organisations as funders and commissioners in all fields want to know the outcomes of projects they fund and the effectiveness of their interventions.

Since 2003 the service has been using Alcohol Concerns Outcomes Programme and this year has seen us introduce their latest tool the 'Alcohol Outcomes Spider'.

This programme developed in consultation with 40 alcohol services around Britain, represents a natural progression of the sustained work carried out by them in developing innovative outcome tools for alcohol services this past ten years.

Since introducing this programme in April 06, we have been conducting a base line interview with clients on assessment in 8 key areas and a follow up on review or discharge. If clients show improvements in any of these key areas from assessment to review they have thus achieved a positive outcome. Reviews take place every 6 months (maximum) per client or upon discharge.

The results detailed below show the eight key areas that are measured: alcohol consumption, social contact/networks, managing physical health, mental and emotional health, employment, crime and community safety, family and relationships and internal journey (or clients understanding and acknowledgement of their personal difficulties and motivation to change).

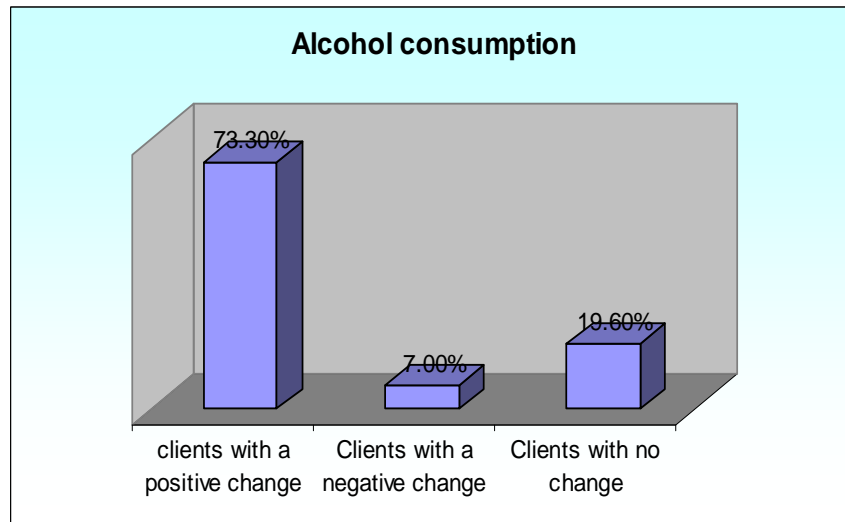
Looking at the charts in detail, it is clear that many clients have made positive improvements and the clients who have negative outcomes and those with no change in their circumstances are low in comparison. Overall the programme reveals many positive changes undergone by the clients who have attended the service.

This programme not only demonstrates the value for money this service brings to the DHSS but the positive changes problem drinkers who accessed this service have made holistically to theirs and their families lives and the community in the past 12 months.

Results

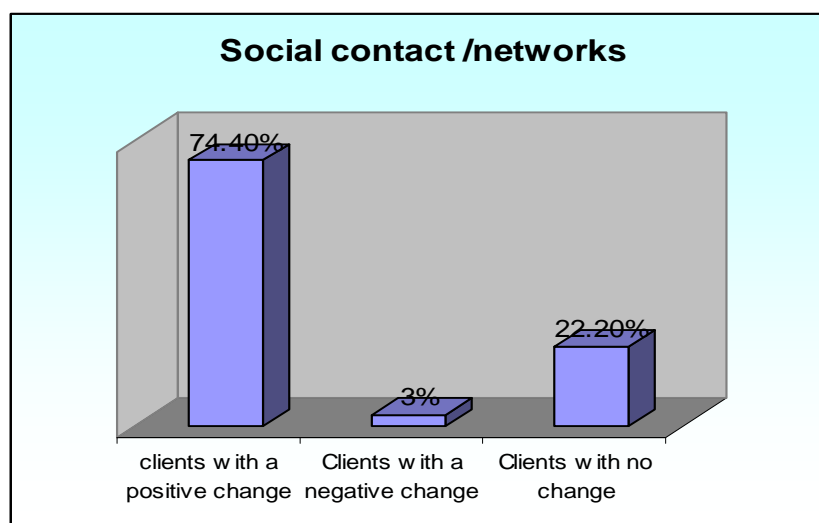
Alcohol Consumption

Lower down the scale clients can be drinking at harmful levels, binge or other harmful drinking patterns or showing strong signs of dependency. Scoring lower on the scale can also indicate mixing substances. They may be attending the service intoxicated and/or not engaging in therapeutic strategies with no recognition of severity of their problem with alcohol. Higher up the scale the client may be abstinent or have achieved their goal of less harmful drinking patterns with a good understanding of triggers to drinking and acknowledgement of the scale of the problem. They may have developed strategies to avoid alcohol misuse and have a relapse prevention plan.



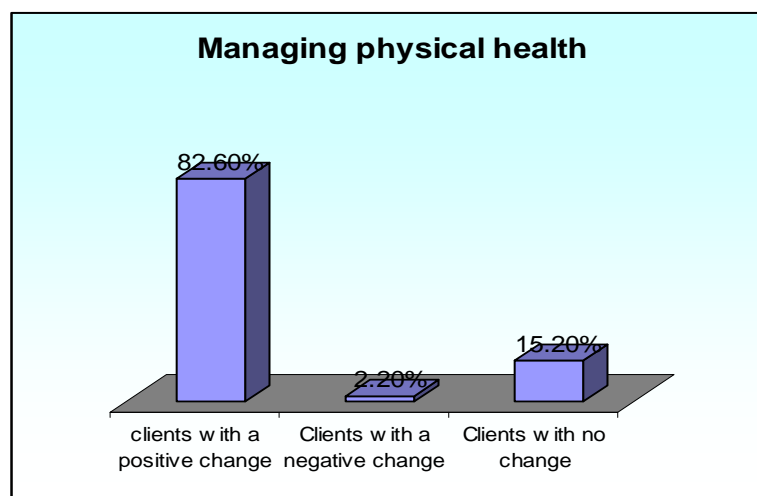
Social Contact/ networks

People may have very different starting points within social networks and this scale is drafted to cover both those who are isolated and want to reduce isolation and those who have plenty of social contact, but within a drinking culture or one that holds them back from alcohol recovery. Improvement within the scales comes with: Contact with people and activities outside of drinking friends/culture; those who are isolated reporting greater ease around other people or greater satisfaction or comfort within their situation; Integrating into less damaging social networks.



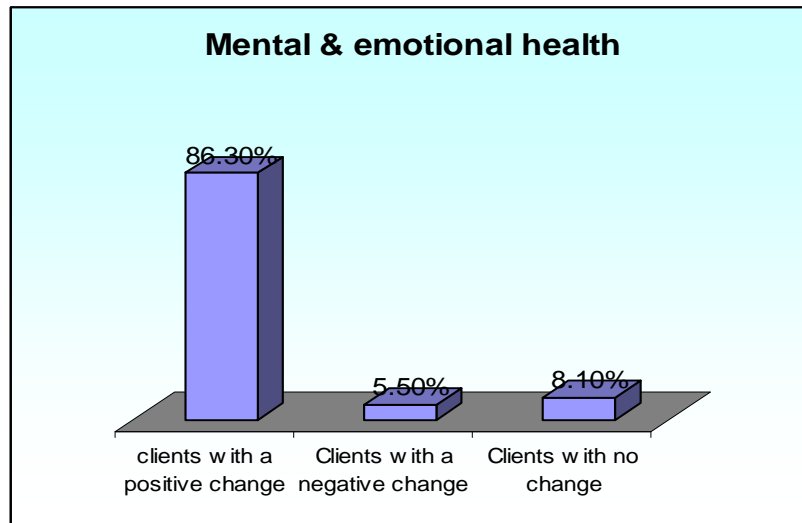
Managing physical health

This scale covers actual improvement in physical health and also user involvement in managing any health problems. Some physical health problems may be too entrenched to see actual health improvements (liver cirrhosis). If this is the case the user may still show improvements by managing health problems. Lower down the scales the client may be drinking at high risk levels and suffering multiple health problems with frequent attendances at A & E and few planned GP or hospital appointments. Higher up the scale the client may be taking responsibility for health and attending planned appointments; gaining or losing weight, improvements in liver function tests, reporting feeling healthier.



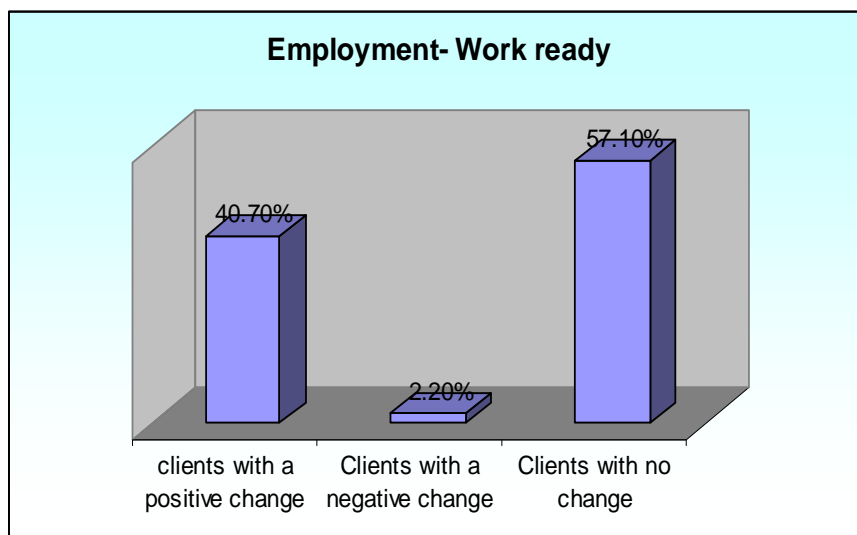
Mental and emotional health

This scale covers both the actual improvement in mental/emotional health and also effective management of health issues. Some of those with diagnosed mental health issues may not show actual improvements in their mental health. If this is the case, the user will probably not proceed higher up the scale, but can still show substantial positive outcomes in taking responsibility and managing issues. At the lower end of the scale the client may be in frequent crises, suffer from suicidal thoughts/attempts, self-harm, frequent bouts of depression, anxiety disorders, low self confidence and self-esteem. Higher up the scale the client may be managing mental health; starting to receive counselling from the service for past trauma, complying with medication regimes, have improved levels of self confidence, self esteem, less frequent episodes of depression, reduction in anxiety disorder.



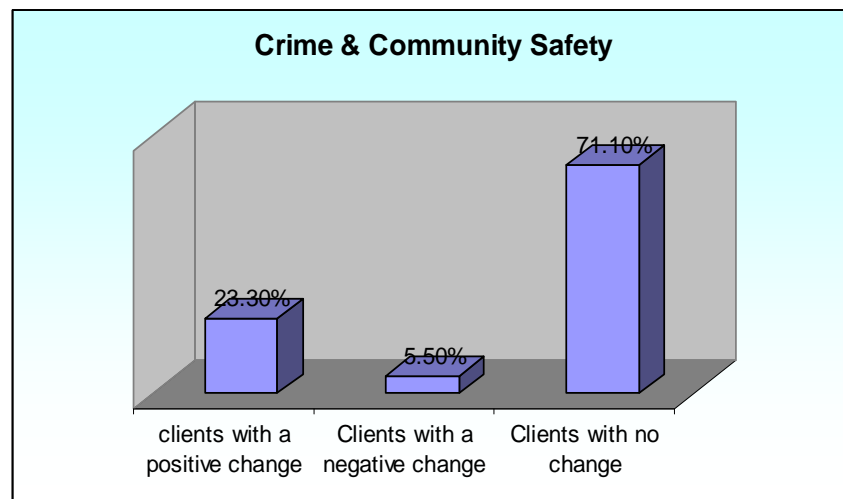
Work ready/occupation

This scale includes aspects of worthwhile activity and structure in the day. Higher up the scale the focus is on engaging with education/work. Many users may not get to this point especially those who are unemployed as a result of alcohol-related offences or losing employment through a drinking problem. They could also be in retirement. At the lower end of the scale the user may be chaotic with no sense of direction or motivation towards purposeful use of time during the day. Clients may score higher when dissatisfaction with their current situation occurs with motivation to explore options for education/training/therapeutic or voluntary work/ hobbies etc. Previous research on employment status has showed many clients to be in employment shows no change is indicated.



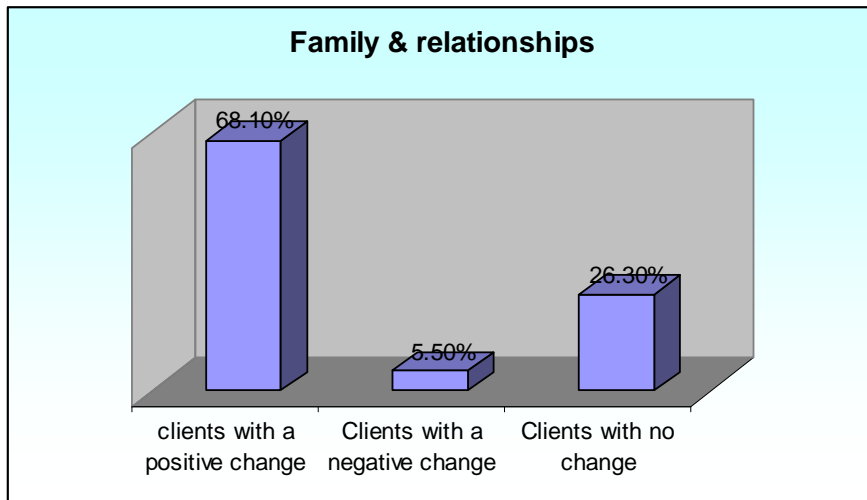
Crime and Community Safety

This scale is included due to the growing interest in community safety benefits among some current and potential funders. It covers all aspects of risk, violence or harm to others, including harm to family and children and including drink driving. It is relevant whether or not a person knows they are committing the crime and whether or not they are caught. However this scale is not relevant for everyone and many will have no past or present criminal activity and will therefore demonstrate no change. Clients at the lower end of the scale will have frequent and recent contact with the police and/or courts and alcohol use will be a contributory factor. Higher up the scale they may accept responsibility and the link between offending and alcohol use and be developing strategies to avoid high risk situations.



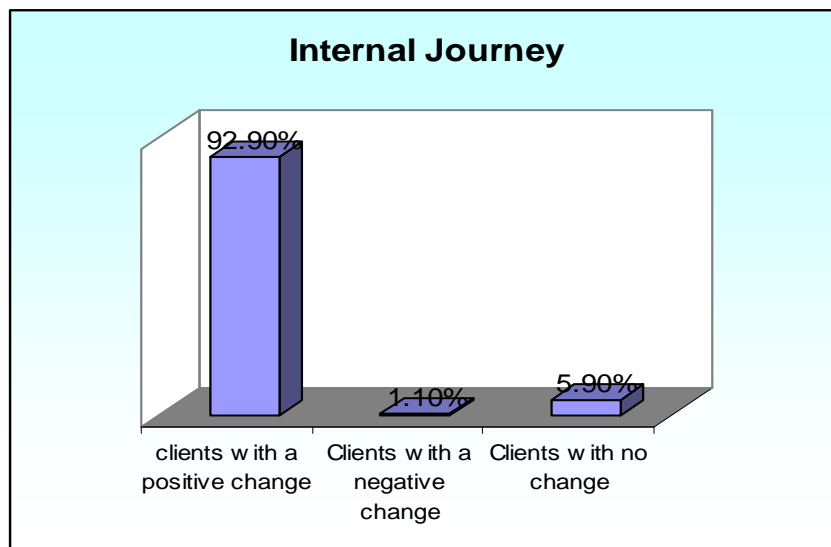
Family/relationships

Lower down the scale a person a client may have little or no contact with family members and there may be very high levels of family conflict. This could include loss/risk of loss of contact with partner/children. They could be attending the service because of these conflicts under duress. Further up the scale they could be starting to explore a way forward in terms of reducing conflict and taking the initiative in improving the family situation. If this is not possible and relations have irrevocably broken down, acceptance this situation and positive separation could be achieved.



Internal Journey

This scale measures the internal journey or process that might manifest as changes in other aspects of a persons life (as measured by the other scales) develop. Some of this internal journey is indicated by how a person is engaging in treatment. At the lower end of the scale the client may have attended the service under duress with family members; they may not be acknowledging there is a problem with alcohol. Moving up the scale will be linked to placement within the stages of change model e.g. stage of motivation; self awareness and acknowledgement of drinking problem; taking responsibility for recovery; exploring treatment options; setting goals; relapse planning and prevention; maintaining progress.



Foetal Alcohol Spectrum Disorder Awareness Day
Report by Jenny Fong
September 8th 2006

Foetal Alcohol Spectrum Disorder is the name given to a range of problems in children whose mother's drank heavily whilst pregnant. It is the leading cause of preventable birth defects in the western world. The disabilities caused by maternal alcohol use are lifelong conditions which are preventable. The National Organisation on Foetal Alcohol Syndrome estimates that for the UK there are more than 6,000 children born with the syndrome and many more with elements of the spectrum disorder.

The Isle of Man's drinking habits are similar to those in the UK with high rates of binge drinking. This includes women of reproductive age. It is therefore reasonable to assume that there will be children born on the Isle of Man who have learning and physical disabilities and behavioural difficulties caused by maternal drinking.

Throughout the world there are awareness campaigns on foetal alcohol syndrome. It was therefore decided that an awareness day should be held to tie in with the international campaigns which are held in September.

The aim of the day was to:

- raise public awareness on the potential harm to the foetus caused by drinking in pregnancy
- to answer queries or concerns that people may have regarding drinking in pregnancy through the use of an information leaflet, discussion with AAS staff and the opportunity to attend the AAS for further information, advice or counselling.

Non-alcoholic drinks were offered during the day as an introduction to alternatives to alcohol. These were provided by Shoprite plc. The Mill Shop at Tynwald Mills funded the production of alcohol and pregnancy leaflet.

Isle of Man newspapers provided a synopsis of the information provided on the disorder in the Isle of Man Examiner.

Members of the public visited the stall ranging from newly pregnant women with queries about drinking in the early stages of pregnancy to grandparents wanting more information on alcopops and teen drinking.

At the time of the awareness day the advice from the Department of Health was that pregnant women should drink no more than one to two units of alcohol once or twice a week. This was put in the leaflets and on the posters with the added statement that as no safe level of drinking in pregnancy has not been established it may be better not to drink at all.

This advice has since been revised to:

“Pregnant women or women trying to conceive should avoid drinking alcohol. If they choose to drink they should not drink more than one or two units once or twice a week and should not get drunk” (Department of Health 2007)



If you drink when you're pregnant so does your baby
(Copied with permission from Addaction)

Peer Alcohol Education Project
Report by Kay Mylchreest

The seed was sown for the above project back in the spring/summer of 2006. There were several reasons why conducting such a project seemed a good idea:

- We had pushed for a number of years for funding to allow us to employ a separate and dedicated young person's worker.
- The EPSAD study of adolescent drink and drug use on the IOM had provided us with some fairly alarming statistics about the level of drinking amongst our young people.
- We knew that peer projects could be very successful (Thea having run one in conjunction with the Girls Group at the youth service a number of years ago)
- Awareness that a variety of educational approaches to alcohol are needed to try and reach as many young people as possible.
- Peer education has been found to be successful for a number of reasons; young people are much more likely to respond to education/advice by other young people; often the people who gain the most are the peer educators themselves – it can build confidence and other skills; peer educators do not have to be academic achievers – this shows young people that talking/listening skills are more important and reach a wider audience.

The actual project was taken from TACADE, one of the leading providers of drug and alcohol school education. The project had been piloted and was thoroughly set out in terms of how to go about organising the project.

We decided that we would like to treat the peer eds as being formally employed by us, so we set about fundraising so that we could pay them. We hoped to employ 12 young people and decided to approach them in areas where we already had good contacts. Ballakermeen High School, IOM College and the Youth Service were decided upon because of the existing good communication links and education already provided by ourselves. Ballakermeen and the College were joined to make one large group and Peel Youth Club formed the other separate group.

In the end, 20 young people from the areas were interviewed and subsequently chosen to begin the training side of the project. The training was done over four 2 hourly sessions and covered topics such as why young people drink, the local statistics and knowledge on young people and alcohol, how to listen effectively to young people, etc. After this it was over to the groups to decide amongst themselves what sort of education project they wanted to come up with, and this was probably the most difficult and challenging aspect of the work. It took several weeks to come with ideas, then more time to discover which of them were actually feasible and workable. In the end, 2 distinct projects were made: Ballakermeen and the College decided to make 2 videos (one is a drama about the possible consequences of a night out drinking too much, the other is a documentary filmed in Douglas on a Friday night interviewing people about their worst experiences through drinking); Peel Youth Club decided to do a research project amongst years 7 – 9 at the QEII around basic alcohol knowledge and form a presentation around the results.

Some 8 months after starting the project, the final presentations were ready! The Douglas group finished their 2 films, 'Too Much Teen Spirit' and 'IOM Booze Confessions'. These have been put on a DVD for use in any educational setting where alcohol issues need to be discussed with young people.

The Peel group collated all their results and put the research and presentation onto a lively PowerPoint display and did this in a combined large assembly for years 7, 8 and 9. Their presentation has also been put onto the DVD as it uses Q & A which would be useful for this age range.

Thea and myself, as well as the rest of the AAS team have been extremely impressed with the energy and commitment these young people have displayed throughout their time with us. They have all gone 'above and beyond' what was expected of them: they met with Comic Relief to discuss the needs of young people on the Island and they responded to an article in the local newspaper regarding alcohol-related hospital admissions.

The groups also organised their own launch and premiere of the DVD including fielding a Q & A session at the end where they were asked questions by MHK's, the youth service, education, etc. We felt that the group had achieved so much that it would be a shame if it could not carry on in some capacity, so we are in the early stages of hopefully getting them together to carry on with a youth forum, which will be carried on by our new young persons post.



REPORT ON ALCOHOL AND THE OLDER PERSON WORKSHOPS PROVIDED
FOR NURSING AND RESIDENTIAL CARE HOMES.

By Debbie Doyle

Drinking moderate amounts of alcohol is an acceptable part of everyday life for many of us. There is no reason why, simply as a result of getting older, this should change. However, there are times for all of us when drinking alcohol is not advisable, e.g. when taking certain medicine, to deal with insomnia or to help relieve depression. The signs of excessive drinking can be similar to those associated with dementia: confusion, clumsiness, poor memory, lack of interest in appearance, mood change and enuresis. For this reason older people's drinking problems can sometimes be overlooked or misdiagnosed. Therefore staff working with the older person may benefit from clear information about alcohol and its effects.

Alcohol misuse among older people is an issue of increasing concern for care workers, health services, and alcohol services. Care workers are ideally placed to identify problems which their clients are experiencing, including problems connected with alcohol use. Sometimes they are unaware of the range of problems which may be associated with alcohol use in the older person, or do not feel confident in raising the issue. The Alcohol Advisory Service set out to remedy this situation by planning a workshop designed for care workers about alcohol and the older person.

The course offered to Nursing homes and care settings is interactive and involves experiential learning. The lengths of the workshops are one to two hours depending on the amount of participants taking part. Role play was included when the numbers were sufficient to allow this to occur.

The aims of the course were three-fold.

- *raise awareness of alcohol-related risks for older people
- *education about alcohol and medication
- *introduce a harm-minimisation (problem solving) approach to alcohol use

Evidence for the workshops

The Isle of Man Alcohol Advisory recently took part in an international survey entitled GENACIS or Gender, Alcohol and Culture International Survey. At this time one thousand adults were interviewed about their drinking habits and attitude towards alcohol consumption. There was a core set of questions asked and this data has now been collated and feedback given to the Manx community. One piece of information gained highlighted the fact that 9% of women were drinking above the sensible drinking levels. Of these 1% was more likely to be in the age bracket 65 – 75 group.

Older people drink for many reasons including loss of home, bereavement, failing health, feeling hopeless, loneliness, to ease pain, isolation and maybe due to addiction to alcohol. The problem often relates in many cases to getting drunk as opposed to long term use of alcohol. The ageing process brings with it a leaner body mass, and a lower level of tolerance of alcohol use.

Consequently the current daily benchmarks or weekly guidelines do not necessarily apply to this age group.

With this information in mind it was decided to approach some nursing and residential homes offering an alcohol workshop designed specifically for the elderly population. Seven of these homes have requested the workshop. To date six have been catered for with one planned for the coming week

FEEDBACK AND OBSERVATION EVALUATION

All of the staff welcomed the opportunity to acquire some knowledge of alcohol issues in general, often commenting verbally that they had a family member who is in need of some advice and help. The talk was arranged after handover which was usually around 2pm. This time suited a larger number of staff, as it allowed those who had finished their morning shift to attend before going home. It also accommodated those who were coming on in the afternoon shift. This time ensured the maximum number of staff attending the alcohol talk. In total 22 staff took part in the presentation and many were of ethnic origin. Interestingly they requested more training on health issues in order to increase their local knowledge.

Occasionally staff had to leave the room and attend to clients needs. This however only occurred twice and only for a short time. Twenty two evaluation forms were returned. During the sessions staff said they had concerns about four clients in various homes.

Evaluation results

Questions in the evaluation included the following:

Do you consider you can now?

- *count drinks in units, and state the daily benchmarks
- *describe the role alcohol can play in older people's lives
- *describe a problem-solving approach to drink related problems
- *list three points to consider when raising the subject of drinking
- *do you know how and where to refer people whose drinking is causing problems

Do you have any comments to make?

Almost all of the questions had been answered although two questions were left blank by two respondents.

20 staff said they understood how to count drinks in units and understood daily benchmarks.

19 staff said they could describe some effects of alcohol of particular relevance to older people and their carers

20 carers said they knew how to use a problem-solving approach to drink-related problems.

22 carers said they could list three points to consider when raising the subject of drinking to the elderly.

20 carers said they had acquired knowledge on the services available at local level and knew the process of referral to these agencies.

The following comments were made.

- *Good presentation in 1 and ½ hours
- *Need to come again and do a follow up
- *Informative and enjoyable
- *Need more study time?
- *Excellent
- *Learned a lot
- *Need to come back
- *Every member of staff needs this lecture
- *Excellent session, lots of valuable information exchanged.
- *Able to ask questions accordingly
- *I found this talk very valuable and will hopefully be able to pass on and use information learned today.
- *Very interesting, would have been nicer to have longer for discussion etc.
- *Interesting, highlighted some issues to think about re: patients coming in.
- *No comment

CONCLUSION

Delivering the presentation has proved invaluable and the feedback was very positive and encouraging. The older population view alcohol problems as stigmatising, they are often reluctant to seek help due to fear, their personal belief system, or feel if they disclose this embarrassing problem they may lose their homes. Research says “special alcohol services not targeted to the needs of older people” and existing services do not always do home visits. If the premises is not on a bus route, or on ground floor level older people are less likely to attend. (Ward and Goodman, 1995)

Older adults often see many different health care providers. Each doctor may not have the complete picture of what is going on with the patient. Hurried office visits and limited training in geriatric issues can contribute to the problem. Many people believe that alcohol and substance abuse problems cannot be successfully treated in older adults. Others think treatment for older adults is a waste of health care resources.

We need to understand what makes older adults particularly vulnerable to the use and misuse of alcohol and prescription drugs. Only then can we prevent, minimise, and reduce the risk. Learning the facts, developing the skills, and having the tools can go a long way to improving the lives of those of those affected in the elderly population.

