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Older adults and alcohol: A study of registered social workers' assessment practices

A thesis presented in partial fulfilment of the requirements for

the degree

of

Master of Social Work

At Massey University, Manawatu,

New Zealand.

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2016

Abstract

Difficulties resulting from alcohol use are a pervasive social issue across New Zealand, affecting people from all walks of life and ages. Registered social workers (RSWs) are ideally placed to breakdown taboos, support people to address difficulties arising from their use, and ultimately to improve our relationship with alcohol in New Zealand.

This thesis explores eight registered social workers' understanding of older adults' (OA) alcohol use and alcohol assessment processes. It is a qualitative study using a grounded theory method to interpret data gathered from semi-structure interviews.

The research initially focused on four core aims: a) whether participants asked OAs about their alcohol use, b) whether participants' perceptions of OAs affected assessment processes, c) whether participants had received any training in this area and d) whether agency assessment tools supported participants in assessment processes. A range of additional findings, extending these aims, were made and are included in the study's analysis. Some of the study's findings endorse current evidence, while some are surprising and sit outside of current literature.

Participants' practice was largely affected by 'perception based practice' possibly leading to negative assessment outcomes for OAs. In fact, alcohol was seen as outside the RSW scope of practice. It is recommended that education, training and supervision be used to develop an 'evidenced informed' model of practice; moving away from a single hypothesis to a multi-hypothesis approach and perception based to standardised questions. This would support an ability to challenge individual and system-wide perceptions, and intervention in-line with what is expected in Codes of Practice.

Recommendations are made for a range of agencies including: District Health Boards (DHBs), the Ministry of Health (MOH), Health Promotion Agency (HPA), Social Workers Registration Board (SWRB), and for the social work profession itself.

Acknowledgements

My most sincere thanks must firstly go to the eight social workers who very generously gave up their time and laid open their understanding and knowledge regarding older adults and alcohol use, without them I would have had no project at all. I was humbled by their openness and honesty.

I have had significant support from many people along the way, several require special thanks: Kristie Saumure Librarian at Ministry of Health, many thanks. Thanks must go to Jan Duke and the Social Workers Registers Board for agreeing to disseminate my initial request for participants. Mention should also go to Chris Sinclair and Suzy Morrison, you both do a great job at furthering knowledge regarding this subject and to Andy Towers for your support.

Thanks to my Boss Toni Atkinson for supporting my study time through a significant period of my Masters and to Gina Lomax for support while at ACC.

Many thanks to my wife Zoey Henley for putting up with the huge amount of time spent in the study room!

My biggest thanks need to go to Associate Professor Kieran O'Donoghue and Dr Michael Dale, who must be the best supervisors a student could have. Thanks for the support and for encouraging me to pursue the particular approach taken; I have learnt an incredible amount undertaking this study.

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Chapter One: Introduction

Alcohol is a socially accepted drug in New Zealand, used on many occasions as a reward or celebration, across genders, cultures and age groups. Resulting difficulties from alcohol use is a pervasive social issue across New Zealand. For Older Adults (OAs), age related changes mean alcohol use can result in a range of health risks. For example, physiological changes related to ageing mean lower levels of consumption can lead to greater levels of risk when compared to younger peers.

Registered Social Workers (RSWs) are ideally placed to breakdown taboos, support people to address difficulties arising from their use of alcohol, and ultimately to improve our relationship with alcohol in New Zealand.

This thesis seeks to explore eight, secondary health care RSWs' assessment practices with OAs and alcohol. Little is known about both RSWs' assessment of OAs and alcohol and OAs and alcohol use in New Zealand, making this research unique. As a result, much of the evidence presented is from overseas.

Populations around the world are ageing rapidly. Baby boomers now entering older age, have used more alcohol than previous generations, this regular use is continuing into older age. The impact of an ageing population is present in many countries around the world, by 2050 twenty two percent of the world's population will be over 60 years old. In New Zealand, a quarter of the population will be over 65 by 2040, a significant increase from 12% in 2005. This increase will require health services to be 'future proofed' and allocation of resources will need to be reassessed in order to meet an increase in demand.

The subject of OAs and alcohol use has received little academic attention in New Zealand or internationally. This is particularly true in relation to how New Zealand based RSWs assess this cohort regarding alcohol use. Currently there exists no New Zealand based research evidence regarding RSWs' processes for assessing OAs and alcohol.

Assessment of OAs regarding alcohol use has particular challenges. For example: OAs may feel stigma attached to alcohol use, OAs may only be assessed if they meet socially constructed perceptions or symptomatology may not be linked to use. Other concerns include levels of

training for RSWs to assess OA and alcohol use, and whether consistent tools are used in assessment processes.

This study explores these issues from the participants' point of view and considers what impacts on their decision-making processes. It is the first piece of work in New Zealand to explore these issues and will contribute to improving current practice, knowledge and evidence in this field.

Research aims and questions

Four research aims are addressed throughout this thesis. They are designed to understand how RSWs based in New Zealand[1] work with OAs to assess their use of alcohol and to develop findings as to how practice could be improved. Each aim is supported by a number of research questions. The aims are as follows:

The first aim was to establish whether participants asked OAs about alcohol use. The main research questions in this section were; 'Should OAs be asked about alcohol use? Why? Do participants ask about this?' If yes, 'How do they do this?' If not, 'Why do they not ask?'

The second aim explored whether socially constructed perceptions of OAs contribute to participants' ability to assess alcohol use. Questions to address this aim included: 'What perceptions do participants have regarding OAs and alcohol use and where do these perceptions originate from?'

The third aim concerned participants' training levels regarding OAs and alcohol use and sought to establish whether training had been undertaken on this subject. A major research question to address this aim was; 'What training in working with OAs and their use of alcohol has been undertaken by the participants?'

The final aim was to establish whether agency assessment tools supported participants to ask OAs about alcohol use. A key research question here was; 'What assessment tools do participants use? Are they supportive and useful?' Also within this aim was a section exploring what services needed to be in place to respond to any needs or risks identified, a main question was: 'What do participants identify as needing to be in place to improve services?'

[1] Working in but not necessarily trained in New Zealand.

Through the process of conducting the research a range of evidence was gathered beyond the original set of four aims. This information has been included in the analysis because it extends the richness of the research. The areas of additional findings are: alcohol and medications were not seen as part of the social work role, the degree perceptions affected practice and practical issues, such as transport and access to services, were seen as important.

Researchers interest in topic

My own values and perceptions regarding OAs were formed from early contact with older family members. I was lucky enough to spend time with all four of my grandparents. My father's parents owned our local fish and chip shop, where my parents both worked in my early years. I spent much time in the shop with my very capable and patriarchal grandfather, who worked until old age; he often drank whisky and always smoked cigarettes, cementing my early impressions of OAs using drugs. My grandmother would often take me out creating a perception of OAs also being caring and generous. My maternal grandparents were also around, my grandmother on this side was a tough Irish woman, the stereotypically fair but very firm grandparent. Neither of these grandparents used alcohol, resulting in my mother having never had a drink. I formed perceptions of OAs being independent, and contributing in many ways.

I had minimal personal contact with OAs following the death of my grandparents. I do recall not wanting to work with this cohort. On reflection, I may have related to the students in Chonody and Wang's (2014), study viewing the work as 'not sexy', and as a male, I may have been drawn into more confrontational types of social work such as mental health and child protection.

As stated my mother has never used alcohol and my father an occasional user. I recall one episode of seeing him drunk, he was wearing my grandfather's hat, with my mother telling him he looked just like my grandfather. Personally, since my late teens I have been a regular heavy alcohol user. I recognise the health risks and possible impact on the health system of my heavy use so I eat well and exercise daily to maintain fitness. I support health professionals asking about alcohol use at each presentation, this increases opportunities for risks to be addressed and importantly normalises alcohol use and conversations regarding alcohol. I recognise alcohol is an addictive and harmful drug, but has become normalised as a result of Western values and skilled marketing.

I qualified to practice social work in England in 1995, since then I have worked in the areas of child care disability, child protection, physical health, mental health and addictions, disability and older adults. I have managed several teams in health settings. Currently I lead a national disability services team for Ministry of Health. In England I also worked as a member of the Emergency Duty team (out of hours' social work) and as an assessor for Post Qualified Portfolios. I moved to New Zealand in 2005 and since 2006 I have worked as a competency assessor for the Social Workers Registration Board.

Before I began this research, I was not aware that due to age related changes OAs face increased risk of harm with smaller amounts of alcohol compared to younger cohorts. While not having negative perceptions of OAs I perceived this cohort as a similar group to other ages, with similar needs.

My interest in the subject of OAs and alcohol use started while setting up an assessment and discharge process for a Lower North Island hospital. I would always ask OAs about their alcohol / substance use, building it into part of the assessment process so it felt comfortable, many OAs would laugh at my questions, while some disclosed fairly heavy use. I was not aware of the literature behind the reasons to ask OAs regarding alcohol, for example changes in physiology that increases risk, but always asked other adults so it made sense to ask OAs. Many colleagues, particularly medical staff did not ask and frequently laughed at my questions. My interest continued when managing a Community Mental Health and Addictions service for the same DHB. We saw very few OAs, those who did attend were older males. When I explored the reasons for so few referrals taking place I found a reluctance of both DHB and Primary health staff to ask OAs about alcohol use.

In a later role with the Accident Compensation Corporation (Programme Manager for reducing harm from falls), I gained greater understanding of OAs and alcohol. As well as developing services around exercise, strength and balance and Vitamin D, I also explored the area of OA's, alcohol use and its relationship to falls. This is a relatively unknown risk area both in New Zealand and internationally. I designed an intervention aimed at OAs titled 'Don't Tipple and Topple' and looked to implement this with a South Island Alcohol Service. Sadly, I was not able to implement before leaving the role, however there was clearly a gap in New Zealand research, regarding assessment of OAs and alcohol, which this study aims to contribute to.

In my current role, I continue to have contact with the Aged Care sector and frequently raise the question of alcohol / substance use, I have recently had some success in discussions with (the then titled) Ministry of Health Mental Health Service Improvement Group regarding the need for a nationally consistent assessment tool. I consider there is a need for consistent assessment processes and tools if risks of harm are to be identified effectively.

Background to study and key concepts

As indicated at the start of this chapter, populations around the world are ageing. 'Baby Boomers' (adults born 1946-1964) use more alcohol than generations before. In recent times numbers of OAs drinking above recommended amounts has significantly increased, with corresponding increases in hospital admissions and treatment, the Baby Boomer cohort have brought many social upheavals one of these is a significant cultural change towards alcohol use (Babatunde, Outlaw, Forbes & Gay, 2014).

Alcohol use by OAs is under reported and under detected. One reason being health professionals' reluctance to perceive this group as alcohol users to the extent of the cohort being termed 'Invisible Addicts' (Crome, Dar, Janikiewicz, Rao, & Tarbuck, 2011), conversely OAs have been identified as binge drinking more frequently than all other age groups. Numbers of OA are increasing significantly and in in NZ the number of OAs who use alcohol, and the amount of alcohol used may be increasing.

There are several concepts relevant to this study: older adults, OAs and alcohol use, assessment, registered social worker (RSW) and evidence informed practice. These concepts are defined below.

Older adults (OAs)

Older age as a concept was socially constructed in the decades following the Second World War. This concept centred on the introduction of targeted services for older people and mandatory retirement ages. These distinctions ensured people received services as required but also effectively placed people over certain ages in the 'box' of older age (Phillipson, 2013).

While several commonly used definitions of OAs exist, there is no general agreement on what age a person becomes old (Morrison, 2012). Some studies classify people into different age groupings, for example 50 and over, 60 and over and 65 and over (Barry & Blow, 2016). In this research 65 years is recognised as an indicator of entering older age.

OAs and Alcohol Use

Alcohol use among OAs is becoming increasingly widespread (Babatunde, Outlaw, Forbes & Gay, 2014). Age directly impacts on the OA with smaller amounts of alcohol having more impact as we age. Hazardous drinking resulting in OAs receiving reduced levels of general health screening from not attending health appointments. This in turn leads to health disadvantages of greater impact than in younger populations (Jenkins & Zucker, 2010). Another complicating factor is an absence of clearly agreed definitions of safe drinking levels for OAs.

A common theme within literature is the degree OA alcohol use is under recognised. Reasons for this under detection are varied: subject knowledge, attitudes or behaviours of professionals may contribute to the issue. Despite the length of concern regarding this subject it remains largely unrecognised. Part of the reason for this could also be a unique challenge facing this cohort; 'Ageism contributes to the problem and to the silence around substance use' (Matua Raki, 2012, p.5).

Assessment

For this thesis 'assessment' is the process a RSW uses to gather information. It does not have to be a formal, structured or recognised process. The fact that social work assessment processes tend to be qualitative and flexible makes the question of participants' perceptions a key part of understanding effectiveness. Assessment involves a clear statement of intent that accounts for values and bias, a systematic process for gathering information, sifting it carefully and reaching an objective and accurate conclusion is a workable definition. Much of this research is focussed on how participants perceive OAs, which means that a key area of inquiry is the extent to which social workers are aware of their own values and bias and the impact these may have on assessments (Milner, Myers & O'Byrne, 2015).

Assessing OAs requires particular skills. Of importance and relevance is using a process of observation and data gathering while clearly identifying strengths, reaching older age suggests the OA has a range of skills and abilities employed to survive.

It should be noted is this study was situated within secondary health settings (e.g. hospital), there were no participants working in a primary health setting (e.g. a general practice clinic) at the time of interview. This sets a clear context for data gathered.

Registered Social Worker (RSW)

In New Zealand, social workers are voluntarily registered under the Social Workers Registration Act, 2003 (New Zealand Government, 2003). The registration process is managed by the Social Workers Registration Board. This was significant to this study as participants needed to be registered to take part. The purpose of the Act is to protect the safety of members of the public, by prescribing or providing mechanisms to ensure that social workers are competent to practice and accountable for the way in which they practice.

RSWs have a recognised New Zealand qualification and are deemed by the Board to be: a fit and proper person to practice social work, competent to practice social work, competent to practice social work with Māori; and competent to practice social work with different ethnic and cultural groups in New Zealand; as well as have enough practical experience in practicing social work (Parliamentary Counsel Office, 2016).

Evidence-informed approach

This study uses an evidence informed, rather than evidence based approach. Nevo and Slonim-Nevo (2011) argue an evidenced-based approach results in research findings overriding judgment and knowledge of practitioners and service users. They prefer instead an evidence informed approach, which allows room for practice to be informed by evidence while still enabling imaginative and constructive solutions. This places service users' needs in the centre and uses empirical evidence as one contributing component. In contrast an evidence-based approach relies on the "Best available research evidence" (Sacket, Haynes, Rosenberg, Gray & Richardson 1996, p. 71). This older medical approach has come under increased critique from social work authors in recent years. For example, Gitterman and Knight (2013) argue evidence-based approaches rely on critical review of available intervention strategies and a linear understanding between research and practice. However, supporters of this approach claim this ensures accountability, lifelong learning and competent practice. Gitterman and Knight (2013) also argue while theory and research are logical and orderly, the lives of people are confusing, disorderly and contemporaneous, requiring rather more creativity and a great deal of curiosity to resolve challenges. In this uncertain environment, social workers need to integrate methods, knowledge and skills in a personal and particular manner, whilst remaining flexible enough to follow people's messages and their own professional judgments. In essence this means working from a position which is informed by evidence rather than based upon it. This understanding

forms the foundation for the argument to progress towards an evidence informed approach throughout the rest of this study.

Structure of the thesis

The thesis is structured as follows:

Chapter 2 is a literature review of the relevant research. This chapter is in two parts, the first explores: a) the context of social work assessments by concentrating on assessment definition and process; b) the literature concerning personal qualities and skills needed to undertake an effective assessment; c) what needs to be considered to ensure the OA receives an effective and outcome focused assessment.

The third chapter presents the methodology used in the study. It explains how a grounded theory method (GTM) was employed, how recruitment was achieved, questions designed, semi-structured interviews were undertaken and how ethical issues were approached and resolved. A significant part of this chapter is the data analysis, which provides a detailed account of coding and the application of grounded theory in the process of analysis and interpretation of the interview data.

In chapter four, details from the participant interviews are presented with six major findings being identified. The fifth chapter compares the major findings to the relevant literature, identifying connections as well as gaps in knowledge.

Finally, the conclusion presents an explanation of the journey undertaken while completing this piece of research, the learnings achieved and a range of implications and recommendations.

Chapter two: Older adults and alcohol use: A review of the relevant literature

Introduction

This chapter explores the relevant literature for the four core aims being studied, that is, to: a) establish whether RSWs ask OAs about alcohol use, b) explore whether socially constructed perceptions of OAs contribute to RSWs abilities to assess alcohol misuse of OAs, c) establish training levels regarding OAs and alcohol use, d) establish whether agency assessment tools support the RSW to ask OAs about alcohol use.

The chapter is in two parts. The first part explores: a) the context of social work assessments, by concentrating on assessment definition and process; b) the literature concerning the personal qualities and skills needed to undertake an effective assessment; and c) what needs to be considered to ensure the OA receives an effective and outcome focused assessment.

In the second part, the available published literature regarding OAs and alcohol use is critiqued within four sections which align with the four core aims described above. Firstly, how OAs and their alcohol use is defined is explored, with consideration given to the evidence regarding whether health professionals ask OAs about alcohol. Secondly, the reasons for not asking OAs about alcohol, including perceptions are considered. Thirdly, evidence regarding training in the area of OAs and alcohol is reviewed. In the fourth section the available assessment tools are explored. This includes a detailed critique of literature covering the range and effectiveness of assessment tools for assessing OAs' alcohol use. The literature concerning the physical impact of alcohol use for OAs and connections between assessments and interventions is also presented.

The literature reviewed was mainly been published within the last ten years, with some evidence being older, but still relevant to this study because it provided original theories and approaches. The majority of published evidence is from overseas as, resulting from the searches undertaken for this thesis, relatively little New Zealand work exists on this subject. Various search parameters and methods have been employed in undertaking this literature review, these included:

- Library searches at Accident Compensation Corporation, Ministry of Health and Massey University, using key words: older person, alcohol, and ageism and focusing on literature within the last 10 years, and the only studies outside of this period included were original significant studies referred to in the recent literature.
- Set Pubcrawler (http://pubcrawler.gen.tcd.ie/) with the words older person, alcohol use.
- Set weekly search engine via Ovid Auto Alert using the set words 'alcohol and older people'.

Part one: Assessment

This part of the chapter explores the nature of social work assessment, followed by a specific focus on social work assessment of OAs.

Defining assessment

The social work assessment process is part art, part science. For it to be an art it would need to be solely reliant on the skill and creativity of the assessor. For it to be a science it would need to be undertaken in a manner that is precisely measured, and follow steps within an instruction manual (Parker & Bradley, 2014). While assessment is a mix of both science and art, it is nonetheless a vital part of the social work process, requiring the assessor to gather required data and form effective relationships with people being assessed

One of the most accepted definitions describes it as gathering information, sifting it carefully and reaching an objective and accurate conclusion (Milner, Myers, & O'Byrne, 2015). This basic description is further refined as; an ongoing process which the person being assessed contributes to, the purpose of which is to help the social worker understand the person being assessed in relation to their environment (Coulshed & Orme, 2012). Bisman (1999) defined that social work assessments determine a person's current situation at a particular time. Assessments should be of value to the person being assessed and / or significant others; this is achieved by providing some form of hope or immediate help (Gambrill, 2013). Assessments therefore provide a role of engagement and data gathering. Assessments also provide a means of ensuring data is accurate and informative, which leads directly to effective interventions (Bisman, 1999).

Martin (2011) claims there is no clearly agreed definition of what a social work assessment is. Gambrill (2013) however, states that an assessment should provide the ground work for setting plans and provide information as to how likely it will be for someone to realise those plans.

Describing the assessment process as being about both art and science raises the question how much individual practitioner's perceptions impact on the process. One of the core elements of this study is to establish whether RSW's assessment processes are critical of socially constructed images, to achieve this, the assessor requires certain skills, an exploration of which is useful.

Social work assessments

Taylor (2012) argues assessment is the start of a social work process, it is central to the identification of need and the beginning of engagement. While important in terms of data gathering and relationship building, assessments are never the end of a process (Walker & Beckett, 2011). Assessment can be an intervention, undertaking a data gathering interview can have a positive impact on a person's well-being (Walker & Beckett, 2011). In contrast, Parker and Bradley (2014) argue the assessment process can also be a negative experience, claiming the social worker needs to focus on ensuring assessments are about making judgements not being judgmental.

Social workers need to remain aware of their own values and bias and the impact these may have on the process (Ney, Stolz & Maloney, 2013). Further to this Couldshed and Orme (2012) state assessments are rarely completely 'true' having been filtered through the lens of the assessor. The ability to be reflective and remain aware of own bias to avoid negative outcomes requires a range of basic social work skills to be used while assessing, these are summarised in Table 2.1 below.

Table 2.1 Skills required to undertake effective assessments

Skills required	*Definition of skills required*
Active Listening	This demonstrates to the person being assessed they are being heard, and listened to, through responses. Some responses will be by signs such as nods, others will be through brief prompts such as 'tell me more'.
Reflecting, Paraphrasing and summarising	These interwoven skills are used to check the assessor has clearly understood the information relayed. They can be utilised by asking 'let me check I have this right' or by repeating back to the person providing the information but in a shortened form. This makes sure the assessor has the correct information and allows the person being interviewed to feel comfortable they are being understood (Martin, 2011). Parker and Bradley (2014) highlight the importance of 'straight talking'.
Gathering information through questioning	Questions form the most important part of an assessment; the assessor is required to use suitable questions dependent on the task being undertaken. While both open and closed questions can be used, open questions such as "How was your journey?" will gather more data that a closed "Did you enjoy your journey?" Questions need to be clear and easy to understand, the use of multiple questions can confuse a person being assessed (Martin, 2011). Also of importance is a sense of humour (Parker & Bradley, 2014).
Analysing and recording information	While gathering required data, social workers need to be able to analyse what information is important and useful and record it in an organised manner. Critical thinking and evaluation skills are required for this task (Martin, 2011). Assessors need to remain mindful of confidentiality (Parker & Bradley, 2014).

Anyone undertaking a social work assessment should know the level of information required and for what purpose it will be used. In addition, there is a need for certain personal qualities,

these are summarised in Table 2.2. Milner, Myers, & O'Byrne (2015, p. 61) suggest an assessment framework in Table 2.3 (page 20). This is referenced as it has connections to the research methodology employed throughout this project.

Table 2.2 Personal qualities required for effective assessments

Qualities	*Definition of qualities required*
Empathy	The ability to understand a person's circumstances rather than focusing on your own perceptions (Martin, 2011).
Unconditional positive regard	Social work assessments can at times explore challenging areas, leaving the person being assessed feeling uncomfortable and vulnerable. Unconditional positive regard enables the assessor to demonstrate shared humanity thus reducing feelings of uncomfortableness (Martin, 2011).
Self-congruence	This quality revolves around 'realness', the worker needs to be open to what is happening around them and accepting their own experiences. Genuineness can enable the assessor to be honest regarding assessments and what may be available to the person being assessed (Martin, 2011).

Agency assessment tools are designed to gather required data from particular cohorts of people, there is currently a gap in New Zealand literature indicating whether RSWs feel supported by using such tools. Walker and Beckett (2011) explain assessment requirements are frequently mandated by employment agencies, forming the 'rules of engagement' which are the context social workers commence assessment processes, a journey that can affect people, sometimes for years to come. According to Matua Raki (2012) assessments can be undertaken in a number of ways from a formal screening tool to simple questions. From the literature searches undertaken for this study, there was nothing pertaining specifically to New Zealand based RSWs' use of formal assessment tools when asking OAs about alcohol use. Within the basic phases of an assessment there are clear differences between formal and informal approaches; the next section explores these differences.

Table 2.3 Assessment framework

(Milner, Myers & O'Byrne, 2015)

Stages	*Task to be completed*
Preparation:	Familiarising with who needs to be seen, what is the background information.
Data Collection	People are met and engaged with. Data is gathered, differences are addressed. Theories are drawn on to answer; Is there a problem and is it serious?
Analysing the data:	Data gathered is interpreted to gain an understanding of the person assessed, this can generate ideas for interventions
Utilizing the data	Finalising outcomes from assessment

Assessment approaches

The allocation of resources is an integral part of the assessment process but little work has been undertaken around how social workers make decisions to allocate resources or how the assessment of a person's needs impacts upon social workers' decision making processes (Joosten, 2014).

Less formal assessments can include a review of a person's circumstances often commenced with a simple "How have you been since we last met?" (Matua Raki, 2012). Sometimes reviews can lead to the identification of urgent matters not previously discussed. Martin (2011) claims this indicates that assessment is not linear but often cyclical, with stages requiring more than a single skill. Assessment itself therefore is a dynamic process requiring the use of several skills, knowledge and values. The social work assessment process is critical in forming any decisions regarding the interviewee (Soniat & Micklos, 2011).

For assessments to be effective the right information needs to be gathered. Less experienced assessors may continue to ask questions and gather more information than is required,

resulting in unclear information (Coulshed & Orme, 2012). Assessments also have limitations, it is not possible to know everything about someone and assessments remain continuous- in this way they are never completed (Johnson & Yanca, 2010). There are many different models or approaches to assessments, the main ones are highlighted in Table 2.4.

Table 2.4 Different assessment models

Model	*Description*
Questioning model	The social worker asks a range of questions to gather information. Critique of this model puts the assessor as 'expert' – interrogating people and making final decisions. Employing the range of skills and qualities covered above may avoid this being a negative experience (Couldshed & Orme, 2012).
Procedural assessment	Places the assessor in the position of utilising assessment forms to be followed and completed. This approach is frequently implemented as a result of legislation or statutory requirements (Couldshed and Orme, 2012).
Narrative assessment	Focuses on the person's social situation, people being assessed and carers are recognised as experts and the aim is to reach an agreed compromise on care needs (Couldshed & Orme, 2012). People being assessed are fully involved in the assessment process (Johnson & Yanca, 2010)
Exchange approach	Takes the exchange of information covered in the Narrative approach a step further. People being assessed are recognised as experts in their situation, assessors are seen as experts in contributing to solutions. This approach relies on the assessor enabling the person being assessed to tell their story (Couldshed & Orme, 2012). Johnson and Yanca (2010) note this approach also needs to gather information pertaining to a person's social situation.

While there are many different forms of assessment risk assessment has, through the years, become integral to social work practice. This is discussed below.

Risk assessment

No discussion regarding social work assessment processes would be complete without highlighting the area of risk assessment. Taking a risk can have both positive and negative outcomes, though in social work risk is often seen as negative. The history of social work risk assessment sits within actuary approaches with the calculation of risk being based upon aggregated data (Kemshall, 2010). In considering approaches to prediction of violent offending the Government of Canada (2016) highlights differences between clinical judgement and actuarial decision-making. The former is by far the most commonly used method, driven by professional discretion and justified by the practitioners' experience and qualifications. This approach has been widely criticised for lacking reliability, validity, and accountability. The latter has been described as mechanical and algorithmic, improving upon the poor reliability of clinical judgments and supporting the assessor to estimate risk posed over a set period of time.

Assessing risk involves many complex and challenging components. There is no clear understanding of what is a risk (what constitutes risk for one person may not be a risk for another) and no agreement on how risk can be effectively measured (Soniat & Micklos, 2011).

Assessing an individual's level of risk is complex and rarely infallible (Martin, 2011) with consideration of the degree of risk critical. Degree is made up of possible level of severity of harm and probability of a particular event resulting in harm (Soniat & Micklos, 2011). One definition of risk assessment identifies it as a diagnostic technique that originates from mental health and medical fields which is carried out by practitioners on a case by case basis (Kemshall, 2008). Alternative writings take this definition further describing the importance of continuing to assess and monitor risk in ongoing pieces of work with service users (Nelson, 2012). This remains important as circumstances change, leaving the worker to consider pieces of information as they are received. One way of undertaking this analysis is to separate the information received into two areas: "Risks that pose a risk to other people and risks to which individuals are exposed to" (Kemshall, 2008, p.140).

One method of reducing risk factors is to ensure effective communication regarding risks takes place within multi-agency and intra-professional relationships. Assessing risk effectively is invariably multi-agency in nature (this is of course, not always possible in rural areas), and the role of each person in the process should be clear and precise. The movement of responsibility across agencies (therefore management of risk) is frequently a result of increased cooperation

(Sheldon & Macdonald, 2009). Regarding assessment each area of social work may need particular consideration, including that of OAs, which is considered in the following section.

Social work assessment of older adults

Populations are ageing around the world (Haighton et al., 2016). By 2050, 22% of the world's population will be over 60 years old (Wadd & Galvani, 2014). In New Zealand 25% of the population will be over 65 by 2040, compared to 12% in 2005 (Statistics New Zealand, 2006). This increase in the OA population will require a refocusing of health and social systems to meet need (Kowal, Towers & Byles, 2014). This refocusing will also require an increased awareness of the OAs needs and factors that should be considered to ensure a successful assessment, these are described below.

Heterogeneity

Like all groups of people OAs all have unique needs, each assessment should be tailored to the person being assessed (McInnis- Dittrich, 2014). Kane, Lacey and Green (2009) inform us there is more heterogeneity among OAs than among any other age group. For example, professionals from all disciplines make many assumptions about OAs allowing ageism to continue.

Age and function

Age and function are not linear- age is not an indicator of a person's ability to function nor of their susceptibility to illness. Functional ability provides some evidence around a person's capability to complete activities of daily living (Naleppa & Reid, 2003). Regarding alcohol use, Kuebris, Sacco, Blazer and Moore (2014) explain that for some OAs a shortened sense of future may impact upon desire to reduce alcohol consumption. Tadros, Mason, Davidov, Davis, and Layman (2015) argue OAs' alcohol use has a greater relevance to function level than strokes, age, cigarettes and sedatives. OAs are at times portrayed by policy makers as having low levels of function or in need of expensive health care services to enable access to a larger amount of limited resources (Kane, Lacey, and Green, 2009).

Unique challenges

OAs face a range of unique challenges: Possible loss of independence, status, hearing, sight, cognitive difficulties, bereavements and impact of multiple medications are some. When assessing an OA these challenges should be taken into consideration and extra time allowed for introduction orientation and discussion (Morrison, 2012). Kuerbis, Sacco, Blazer, and Moore

(2014) claim OAs generally respond better to supportive non-confrontational approaches and are more likely to disclose relevant information if they believe the person assessing is genuinely interested.

One final unique challenge is; health agencies frequently do not address alcohol use in OAs as a direct result of ageism, rather perceiving OAs as a group who do not use alcohol (Kane, Lacey, and Green, 2009).

Physical barriers

The way health services are currently set up may not be suitable for the OA. Any physical barriers should be addressed; clinics maybe unwelcoming or even intimidating (DrugScope, 2014). There may also be barriers such as transport or mobility difficulties or even a lack of useful advertising for this particular cohort regarding services available (Murdoch, 2014; Wilson, Jackson, Crome, Rao & Crome, 2015). Social workers need to remain aware of these issues and address them where possible.

Ageism

The term ageism was coined by Butler (1969), to describe the view of OAs as useless, a drain on society and in decline. According to Kane (2008), society widely condemns other forms of discrimination, while ageism remains the most encouraged and accepted form of prejudice in modern culture. Ageism is unique as it is the only form of discrimination everyone may experience (Chonody & Wang, 2014). Chonody and Wang (2014) highlighted ageism in social work practice demonstrating student social workers believed working with OAs was depressing, and OAs themselves are depressed, lonely or have poor hygiene. Ageism is thriving in current health systems which results in OAs being seen as experiencing conditions without cure (dementia) and therefore interventions are pointless. Kane (2008) terms this therapeutic nihilism (refusing or not recognising people for treatment). Allport (1954) argues that Contact Theory (exposure to a certain cohort of people) will lessen negativity towards that particular group. However, Chonody & Wang (2014) argue brief work based contact may not be enough to influence attitudes. A clear argument that perceptions are a critical part of how assessments of OAs are undertaken.

Effective assessments will need to identify strengths. Having reached older age suggests that the OA has a range of skills and abilities employed to survive (McInnis-Dittrich, 2014). However, Kane, Lacey and Green (2009) found social work students perceived this cohort as vulnerable,

oppressed and marginalized. This raises questions regarding the ability of social workers to complete effective assessments.

Any assessment should focus on rapport building (Crome, 2013) as OAs may feel uncomfortable as a result of low self-esteem or difficult relationships with either professionals, or family members. Some OAs may struggle with stigma resulting from alcohol use (Wadd & Galvni, 2014; Wilson et al., 2015). The nature of OA assessments can have additional challenges, which practitioners may not realise. For example, an OAs' symptomatology may not be linked to substance misuse, presentations may only be linked to 'aging diseases' or functional difficulties (Crome, 2013).

Part One has covered the process of assessment and the skills required to do it well. It has also begun to raise points regarding the challenges of assessment of OAs. One of these challenges, in this instance alcohol, requires a more detailed exploration, which is provided in Part two.

Part two: The older adult and alcohol

The second part of this chapter explores the relevant literature pertaining to OAs and alcohol use. It is structured to align with the four aims of this study and examines the literature regarding: asking OAs about alcohol, perceptions of RSWs; training received by RSWs; assessment tools used by RSWs; and the relationship between assessment and treatment. The chapter is rounded off with a conclusion that summarises the main themes from the literature.

Asking OAs about alcohol use

The first aim of this study relates to whether RSWs ask OAs about alcohol use. This is fundamental to this study and an exploration of the relevant literature firstly requires a review of the evidence related to OAs as alcohol users and impact of use.

Alcohol use, especially in a hazardous manner, can have negative impacts for OAs on social, psychological, physical and economic wellbeing (Haighton et al., 2016). Hazardous drinking is connected with OAs receiving reduced levels of general health screening, which can result in health disadvantages of greater impact than in younger populations (Jenkins & Zucker, 2010; Wilson et al., 2015). To be able to support OAs regarding alcohol an ability to recognise OAs as drinkers is vital. A lack of practitioner knowledge is a significant barrier to this (Dance & Allnock, 2013; Murdoch, 2014). Impact of alcohol can be widespread, at any one time a social worker

practicing in adult services will be working with people whose lives are affected by alcohol (Galvani, 2015). Wadd and Galvani (2013) indicate that OAs can be acutely aware of the stigma of alcohol misuse, leading to shame and embarrassment, itself a barrier to identification. One of the key ways of removing these barriers is building good rapport and relationships.

OAs are less likely to recognise a substance issue themselves, therefore they are less likely to seek treatment (Cooper, 2012), meaning frequent opportunities for screening are important. In a New Zealand context Khan, Wilkinson and Keeling (2006) highlight that physician advice is connected with OA alcohol reduction and health professionals should attempt early detection and screening. Hanson and Gutheil (2004) indicate practice knowledge and research regarding OAs and alcohol is poorly developed leaving the social worker to be creative in finding practice solutions. These circumstances demonstrate the need for New Zealand based social work research. This study aims to contribute to reducing this gap in knowledge.

In regard to the international literature, a survey of 171 primary health doctors in the USA, found that 27% did not regularly screen older patients for alcohol use. One of the reasons given was reluctance of OAs to answer alcohol based questions (Reid, Tinetti, Brown & Concato, 1998). Dance and Allnock (2013) found 41% of UK based social workers and other health practitioners working with OAs never ask about alcohol or drug use. From the searches undertaken for this study no comparable data for RSWs in New Zealand was found.

What is known is that routine assessment for alcohol misuse in New Zealand is not common practice among General Practitioners (Mules et al., 2012). An exception to this is Gifford, Paton, Cvitanovic, McMenamin and Newton (2012), who, in one New Zealand region, completed an alcohol screening trial for all ages between May 2010 and January 2011. Results indicated almost 25% of people screened were drinking contrary to guidelines. These authors found if this process was implemented throughout New Zealand there would be considerable scope to address alcohol misuse. This trial demonstrated screening is a successful intervention for identifying alcohol difficulties across ages, what is unknown is whether New Zealand based RSWs ask OAs about alcohol, this study seeks to explore this gap in knowledge. Also of relevance here are the reasons for OAs using alcohol.

There are many reasons OA use alcohol, the literature searches undertaken for this study demonstrated that alcohol performs many functions among OAs. A study comprising of interviews with 21 individuals and three focus groups in the UK found several reasons OAs

drink, these included: enjoyment, to relax, and a sense of camaraderie with other drinkers (Ward, Barnes & Gahagan, 2011). Other research found OAs use alcohol to manage stress and chronic pain and not recognising this demonstrates a lack of understanding of underlying reasons for use (Wadd & Galvani, 2014). In the New Zealand context, little is known about OA alcohol use (Hodges & Maskill, 2014).

A survey of 1395 OAs in Finland, found positive reasons for use, similar to those listed above, but also several negative reasons, including the feeling of having a meaningless life, self-medicating and depression (Immonen, Valvanne & Pitkala, 2011). Many older people begin drinking as a response to stressors of ageing (Wadd & Galvani, 2014), rather than being less of a concern as a person ages, alcohol use appears more pronounced. This evidence begins to provide a picture of alcohol use in the older population, levels of recommended and actual use should now be considered.

McEvoy, Kritz-Silverstein, Barrett-Connor, Bergstrom and Laughlin (2013) found a high number of OAs drink above recommended guidelines. Other literature, which focusses on actual use, states OAs who drink in hazardous ways, drink a similar amount to younger drinkers (Christie, Bamber, Powell, Arrindell & Pant, 2013). Consumption places the OA at risk of negative consequences regarding: functional levels, emotional deregulation, social vulnerability and general health wellbeing. For the OA risks are relevant at much lower levels of consumption than for younger counterparts (Sorock, Chen, Gonzalgo & Baker, 2006). These changes combined with frequent multi-medications can result in impairments of activities of daily living from alcohol (Haighton et al., 2016). Alcohol therefore is a serious risk for OAs, health professionals should be frequently screening, however according to Schonfield et al. (2010) few OAs are screened, meaning few access interventional services. These risks require some explanation.

In New Zealand, the number of OAs who use alcohol, and the amount of alcohol used, may be increasing. This may vary across age cohorts (Nelson, 2012). People over 70 years may experience risk of alcohol withdrawal syndrome (AWS) at greater rates than younger counterparts. This results from a range of medical and neurological conditions and a longer use time (Taheri et al., 2014). AWS symptoms can easily be missed as they are similar to other age related presentations. This sits alongside increased medical complications from withdrawal of alcohol including: hallucinations, seizures, delirium and cardiovascular instability. OAs require

appropriate assessment to ensure symptoms do not escalate (Murdoch, 2014). This requirement is in direct contrast to what Kane, Lacey and Green (2009) claim takes place; professionals and families will excuse or ignore alcohol difficulties' in the OA, perceiving them to only exist in younger cohorts or believing recovery to be impossible. Alcohol use among OAs has received little attention in New Zealand (Paech and Weston 2009), this study will contribute to addressing this lack of local information.

A social work assessment of OA's alcohol use should include considerations around physiological changes that take place for the OA (meaning that alcohol can have greater impact even at lesser amounts), these are highlighted in Table 2.5.

Table 2.5 Physiological changes to consider

Issues	*Items to consider*
Particular physiological changes to consider when assessing OAs	An increase of fat ratio compared to water. Hepatic blood flow reduced. Inefficient liver enzymes (Nelson, 2012).
	Altered brain responses resulting in quicker depressive effects. (Murdoch, 2014)
	Increases to neuronal receptor sensitivity, results in higher blood alcohol concentrations (Kuerbis et al., 2015). Age modifies the body's responses to alcohol particularly the rate of absorption, distribution and excretion (Sharp & Valch-Haase, 2011).

The factors listed can result in the OA having an increased concentration of alcohol, meaning an enhanced level of toxicity, which results in lower doses affecting the OA (Kuerbis et al., 2015; Nelson, 2012). OAs are more vulnerable to the physiological effects of alcohol than younger counterparts, even small amounts of consumption can lead to a range of health difficulties, which are exacerbated by alcohol interactive medications (Barry & Blow, 2016). Having identified risks some consideration needs to be given as to whether those risks are being effectively assessed.

A required step in identifying OAs at risk of harms from alcohol use is health professional and service user conversations, frequently these conversations do not take place. There are several reasons for this, for example; ageist perceptions (Murdoch, 2014), a belief that OAs will not be candid regarding use and lack of time (Beich, Gannik & Malterud, 2002). In New Zealand, Burns (2015) identifies the following myths: OAs are too old to change, it is wrong to interfere, OAs are entitled to consume and should not be robbed of their last pleasure. These reasons are all derived from health professional perceptions of the OA, again highlighting the importance of this piece of research. Another New Zealand based study regarding alcohol screening across all ages found less than 10% of people who drank in a harmful manner discussed this with their health provider (Foulds, Wells, Lacey, Adamson & Mulder, 2012). Murdoch (2014) argues every health professional has a responsibility to address the issue of alcohol use by including it in every routine assessment of an OA.

Patient defensiveness is another significant barrier as to why health professionals do not ask about alcohol (Coogle & Owens, 2013). According to Wilson et al. (2015), OAs create barriers to screening, being up to four times less likely to report alcohol issues than younger drinkers. The reasons for this include self-perceived ‘moral weakness’ and stigma. The range of issues impacting on low levels of screening for alcohol use among OAs are summarised in Table 2.6 below.

A connected challenge is identifying the OA who presents with alcohol risks. An alcohol influenced presentation may be seen as part of ageing such as: falls, confusion or depression. Adding to the complexity is that an Alcohol Related Brain injury can manifest in poor balance (Matua Raki, 2012). Health professionals also have difficulties in distinguishing between dementia type presentations and those that may have alcohol as its origin (Dance and Allnock, 2013). This presents a challenge as GPs will respond more positively to physical conditions (Taheri et al., 2014).

Table 2.6 Healthcare and individual barriers to identifying use

(Murdoch, 2014)

Healthcare Practitioner and individual barriers to detection and diagnosis of alcohol use	
Practitioner barriers	**Individual barriers**
Ageist assumptions	Attempts at self- diagnosis
Failure to recognise symptoms	Symptoms attributed to ageing process or other illness
Lack of knowledge about screening	Many do not seek treatment
Discomfort with topic	Perceived stigma of the word addiction
Lack of awareness of substance use in OAs (if you don't think about it, you won't see it)	Reluctance to report because of shame, denial, desire to continue and pessimism about recovery
Use traditionally considered unusual in OAs	Cognitive problems, substance induced amnesia, underlying dementia
Symptoms may mimic or be hidden by those of physical illness	Unwillingness to disclose
Unwillingness to ask	Confusion of informant(s)

Irrespective of any uncertainty the responsibility of healthcare workers is clear; any OA presenting with a range of conditions such as: chronic disease, gastrointestinal problems, incontinence, hypotension, falls as examples, should be screened for alcohol use (Caputo et al., 2012). Therefore, alcohol should always be considered as an underlying cause rather than health professionals looking to find evidence to undertake screening. Using this as a premise for good practice allows the opportunity for developing integrated practice frameworks based upon values, knowledge and skills.

Alcohol is a risk for OAs at lower levels of consumption than younger counterparts, and health professionals do not routinely ask this cohort about use. There are a range of reasons for OAs not being asked, many of these pertain to uncomfortableness and perceptions of the OA. From the literature reviewed there is currently a gap in New Zealand evidence regarding whether

RSWs ask OAs about alcohol use. The next section addresses reasons as to why it may not take place.

Perceptions

Following on from the evidence regarding whether OAs are asked about alcohol, this section relates to the second aim of whether practitioner perceptions (as in the way a particular cohort is seen) impacts on practice decisions. An important role of health professionals is to remove commonly held myths around OAs and alcohol use, because some OAs do use alcohol and are of particular risk from its effects (Crome, 2013). Not only are a significant number of OAs regular alcohol users, high numbers use above recommended levels (McEvoy et al., 2013), and many of this cohort use a similar amount to younger drinkers (Christie et al., 2013).

Misconceptions held by health professionals are a key factor as to why OAs are not asked about alcohol (Wadd & Galvani, 2014). There is reluctance within health agencies to discuss alcohol use with OAs, which correlates with the issue being under diagnosed (Christie et al., 2013). Overall use of alcohol within the OA population is traditionally under diagnosed and undertreated (Ekeh et al., 2014), contributing to this under detection are socially constructed perceptions of OAs which impact on practice. Reasons for this include many professionals believing OAs cannot be treated successfully and many lacking the energy to attempt to treat people so near to the end of their life span. This is despite evidence that results for OAs following treatment is matched or superior to that of younger adults (Sharp & Vacha-Haase, 2011). Wadd and Galvani (2014) claim health professionals can be embarrassed about asking or simply do not recognise alcohol as part of their role.

According to Raskin and Widrick (2010) the formation of socially constructed messages can be explained as the golden section hypothesis which suggests that people follow a consistent blueprint of cognitive organization when interpreting sensory information. People are generally perceived positively in around 61% of cases, whereas OAs are perceived in an inverted manner only being perceived positively in 40% of instances. This theory is demonstrated elsewhere in this study by evidence highlighting both students and RSWs viewed OAs in a negative light (Chonody & Wang, 2014; Hooyman & Lubben, 2009). Therefore, if a cohort is viewed negatively this can result in individual members of that group receiving an assessment influenced by this perception. Placing this concept within a practice framework, Scott (1989) claims perceptions results in social workers seeking to confirm initial assessment data. Seeking alternative

evidence and employing hypothesis development to explain findings was rarely used, therefore perpetuating beliefs. This practice framework provides some understanding for the continued impact of socially constructed perceptions upon practice. Whether the decision making of New Zealand based RSWs is impacted by socially constructed perceptions is currently unknown, providing some information regarding this is one of the four aims of this research.

There are a number of theories about how practitioners' perceptions impact their ability to effectively assess OAs. Socially constructed images can be formed when not challenged at an early stage. Chonody and Wang (2014) found students perceived OAs as a depressed group with poor hygiene. Kane (2008) claims ageism in health settings results in therapeutic nihilism. Contact Theory, (Allport, 1954) offers an alternative view of exposure to certain groups will lessen negative beliefs. Chonody and Wang (2014) however, challenge this claiming work based contact, as opposed to family or social based contact, is not enough to reduced socially constructed beliefs.

Allen, Cherry, and Palmore (2009, p.132) term an inability to see a different reality than what has been constructed over time as 'cognitive laziness'. One example of this being the perception of OAs not being alcohol users. Kane, (2008) notes that age-sensitive training curriculums may help to lessen these negative influences on practice. This relates back to Allport's (1954) Contact Theory outlined above, as Allen, Cherry, and Palmore (2009) explain personal contact and relationships with OAs will create positive perspectives towards that cohort.

Reasons for not asking OAs about alcohol use include stereotyping, (for example, not asking older women about alcohol), and a lack of training and awareness (Wilson et al., 2015). Similarly, Sharp and Vacha-Haase (2011) state training and awareness is needed to increase confidence around alcohol use and OAs. Ageism is frequently encountered regarding OAs and alcohol use from relatives as well as professionals (Wilson et al., 2015). Similarly, Maclean, Gill and Breckenridge (2015) argue ageism and lack of knowledge contribute to screening not taking place.

Lack of awareness regarding OAs and alcohol use results in risks not being identified, with physiological changes from ageing meaning impact of alcohol can be exacerbated. Many of the well-known 'geriatric giant' disorders for example, incontinence, instability, immobility can be linked with alcohol (Crome, 2013; Murdoch, 2014). Kuerbis, Sacco, Blazer, & Moore (2014)

claim rates of alcohol use by OAs are significantly underestimated, with the misconceptions of health practitioners not asking OAs alcohol related questions contributing to this (Murdoch, 2014; Wadd & Galvani, 2014). The gaps in New Zealand based social work literature clearly highlights the need to explore whether RSWs as participants ask OAs about alcohol use and whether perceptions impact on this process.

This section demonstrated a range of reasons health professionals do not ask OAs about alcohol use. Lack of belief in effective treatment, cognitive laziness and socially constructed perceptions all play a part. Some health professionals appear to not feel comfortable asking and some feel it is simply not part of their role (Wadd & Galvani, 2014). Conversely some feel embarrassed or believe it is wrong to remove a final pleasure in life (Murdoch, 2014; Wadd & Galvani, 2014).

Galvani (2015) simplifies this premise claiming many social workers and health care professionals do not know what to do regarding working with people who use substances including alcohol. Also, discussed in the literature are reasons, many concerning perception, that social workers do not choose to work with OAs, these include: OAs are unable to change (Gellis, Sherman & Lawrance, 2003), undertaking work with OAs is not rewarding (John A. Hartford Foundation, 2009) or that working with OAs has a lower salary and therefore lowered status (Hooyman & Lubben, 2009).

These perceptions build a general feeling of negativity towards OAs, contributing to creating an impression this cohort has little to contribute to society in general. This thesis explores whether RSWs hold socially constructed perceptions and if so how they impact upon practice decisions. Consideration needs to be given to how these impacts can be addressed; as such the following section presents the evidence regarding the need for training to reduce the impact of perceptions on assessment effectiveness.

Training

This section aligns to the third aim of this thesis; establish whether training had been undertaken on this subject. It considers the literature pertaining to what training is required to make assessment of OA's alcohol use effective. General issues are presented first followed by more specialist areas: patterns of alcohol use, gender differences, alcohol related injuries and health promotion literature.

Training, and more generally lack of knowledge, is mentioned frequently throughout the literature regarding OAs and alcohol use. With knowledge being integral to all aspects of social work practice. Many social workers feel they have not received enough training to be comfortable working with OAs (Cummings & Alder, 2007; Olsen, 2007). Wang and Chonody (2013) argue a lack of formal training regarding working with OAs may contribute to social workers' negative perceptions of this cohort. While Wadd and Galvani (2014), state social workers need to be able to work effectively with OAs who experience shame around alcohol use. Training those working with OAs and focusing on screening and non-judgmental practice would improve skills and outcomes (Barry & Blow, 2016).

Dance and Allnock (2013) found the majority of alcohol training in the UK was aimed at social workers working with younger people, training around OAs and alcohol being rarely offered. Information demonstrating whether RSWs have completed any training regarding OAs and alcohol in New Zealand is currently not available. Data regarding this gap of local knowledge is presented in this thesis.

Addressing alcohol use is part of a social workers' role and clarity regarding responsibilities in this area needs to begin at training level (Galvani, 2015). Social work education needs to support front line professionals to safely intervene in the lives of people experiencing difficulties with alcohol (Wadd and Galvani, 2014). Tadros et al. (2015) take this argument further stating; health care workers are often not adequately trained in the assessment or recognition of difficulties regarding OAs and alcohol. Similarly, Wadd and Galvani (2014), argue social work training needs to be developed regarding OAs and alcohol use. Three main areas of knowledge are required for social workers to be able to effectively support OAs with alcohol presentations, these are explored below.

Patterns of alcohol use

In a similar way that there are many reasons that OAs use alcohol, there are also many reasons for changes in drinking patterns. One UK study of 6,011 older men and women found over half had changed their drinking habits over a period of a decade. Of these 40% had decreased with 11% increasing. The most common reasons for these changes were health precautions and reductions in social engagements (Britton & Bell, 2015). This study explores whether RSWs are aware of differences in drinking patterns among OAs. Current literature identifies three patterns of alcohol use among OAs, these are summarised in Table 2.7.

Table 2.7 Patterns of use

Patterns of use	*Description*
Early On-set	Long term (often lifelong) pattern of heavy drinking (Bakhshi & While, 2014). Predominantly males who have chronic and complex social and alcohol related difficulties. This cohort is generally less amenable to attempts to change drinking habits and is often well known to treatment services. (Rakshi, Wilson, Burrow, & Holland, 2011).
Late On-set	Commenced drinking alcohol at a later age, frequently to help cope with factors associated with ageing: poor health, bereavement and isolation (Bakhshi, & While, 2014). This group is not so well known by health agencies or referred to treatment services, but will often have a hazardous and harmful pattern of use. (Rakshi, Wilson, Burrow, & Holland, 2011). Up to a third of all older drinkers meet late onset criteria. (Wang, Steier, & Gallo, 2014).
Intermittent Drinkers	Some evidence points to the existence of a third group of Intermittent drinking at any age. This group of older people will generally binge drink more than 5 drinks at each session (Christie et al., 2013).

In New Zealand, there are ethnic and social differences among OAs, for example, Marie, Fergusson and Boden (2012) claim consumption rates for Maori are 1.47 times higher than non-Maori (15 - 30 years), socioeconomic factors in New Zealand contribute to this difference. While these differences are important to note they were not a focus of this study. In contrast OAs with higher levels of income and education with better health status and male are more likely to drink in an unhealthy manner (Tadros et al., 2015). Connected to patterns of use are gender differences, these are explored below.

Gender patterns

OA drinking difficulties are more prevalent among older men, but this phenomenon appears to be changing. A twenty-year longitudinal study of 719 OAs in California supports the evidence that men are far more likely to develop a drinking difficulty (Moos, Schutte, Brennen & Moos, 2009). However, the role women play in drinking environments has changed greatly over the past 50 years. Far from being seen as ‘neglectful mothers’ if drinking, women are now heavily targeted as consumers (Emslie, Hunt & Lyons, 2011).

Though men are reported as being far more likely to drink in a hazardous manner, women are less likely to disclose hazardous drinking levels than men. This possibly affects data gathered, to the extent that across Australasia actual rates of binge drinking may be comparable between the genders (Gell, Meier & Goyder, 2014).

There is evidence to indicate that alcohol negatively impacts on women more than men. According to Yoneyama and Lima (2015) women develop alcohol related cardiomyopathy at lower levels of alcohol consumption and over shorter periods of drinking. While moderate levels of consumption can reduce the risk of heart attack for both genders Yoneyama and Lima (2015) claim this benefit appears far lower in women. Having established patterns and some degree of possible harm connected to alcohol consumption consideration needs to also be given to injury resulting from use.

Alcohol related injury

Alcohol use among OAs presents the additional risks of falls and injury. Of people sixty-five years plus, who have presented to hospital emergency departments 14% have a history of problem alcohol use (Wang, Steier & Gallo, 2014). A connection between alcohol and falls is clearly demonstrated in the research evidence (Hegman et al., 2010; Wilkinson & Dare, 2014). Finkelstein, Prabbu and Chen (2007) claim older men who drink alcohol in excessive amounts are 4.5 times more likely to fall and sustain an injury than those who do not. For women, the figure is an increased risk of 3.7. This evidence demonstrates alcohol use in the older population increases risk of injury. Conversely, Alliston (2012) in a study of a number of systematic reviews on factors which increased falls found that alcohol was not identified as one of the major risks. Though evidence is mixed alcohol use clearly plays a role in OAs falls and injuries, suggesting further work is needed to establish the significance of its role.

OAs presenting with injuries are less likely to be screened for alcohol than younger counterparts, resulting in possible underestimation of prevalence of use (Beasley et al., 2014). Tadros, et al. (2015) found alcohol related disorders were highly significant to OA's Emergency Room presentations. In the United States (between 2006- 2011) 1,620,345 OAs attended an Emergency Room for alcohol treatment, of these 66% were admitted as in-patients. With this data in mind if an OA presents with an injury (resulting from falls as an example) they should receive alcohol screening or an opportunity is missed to offer interventions (Tadros et al., 2015).

In a World Health Organisation (2007) study New Zealand ranked second among 12 countries for alcohol related injuries (36% compared to 20.4% average). This demonstrates New Zealand's significant connection between alcohol and injury. Discussion of injuries links into the provision of health promotion information explored below.

Health promotion and information

There is limited evidence that effective health promotion literature aimed at OAs and alcohol exists in New Zealand (Hodges & Maskill, 2014). A review of the literature from searches undertaken for this study indicates two main forms of health promotion and information for OAs. They are health promotion and alcohol advice. One example is; Alcohol and Older people: Information for older people, family, friends and carers (Health Promotion Agency, 2008). This booklet provides basic advice and information regarding alcohol use for the OA and carers. Many OAs, particularly men, are unaware of safe drinking advice (Gilson, Bryant & Judd, 2014), with DrugScope (2014) identifying lack of awareness of safe drinking levels as a major barrier to effective treatment.

General alcohol information and recommendations regarding consumption levels are in place for working age adults in many countries; despite this alcohol is the most widely used drug across all ages. A larger percent of OA men drink in a hazardous manner than men across all ages, with OAs drinking in more hazardous ways than ever before (Towers et al., 2011). However, caution must be used when trying to compare data due to many variables in definition and data gathering methods (Gell, Meier & Goyder, 2014), this is particularly true internationally. Towers et al. (2011) explain that the variance across countries is influenced by: cultural differences in drinking patterns, use of different screening tools, definitions of drinking, or different populations resulting in a lack of clear prevalence of hazardous alcohol use. Other factors include that the simple difference in size of 'alcoholic units' internationally affects the ability to compare rating scales (Bright, Fink, Beck, Gabriel & Singh, 2015). This evidence would suggest information, as a form of intervention, is not effective and that prevalence comparisons, should be analysed with caution.

Significant amounts of older males use alcohol in a regular manner in New Zealand. Towers et al. (2011) claim figures of 56%. This data was gathered using the Alcohol Use Disorders Identification Test- C (AUDIT-C) which is a modified version (it contains three questions instead

of 10) of the AUDIT tool. Towers et al. (2011) note this tool is traditionally used for inpatients, with community based OAs there is risk of over-estimate of prevalence use by 33%.

Other evidence demonstrates a significant percentage of Australian older men drinking in a hazardous or harmful manner. One study, undertaken by Bright et al. (2015) utilized the A-ARPS (Australian- Alcohol Related Problems Survey) a tool designed specific for older adults, taking into consideration physiological changes, medications and medical presentations. This study resulted in a figure of 82% of OA males drinking in a harmful manner. Location and circumstances play a large part on prevalence rates, for example Tadros et al. (2015) claim rates for OAs who drink in an unhealthy manner living in Aged Residential Care can reach 40%.

There remains confusion regarding consistent advice for OA and consumption levels. Gilson, Bryant and Judd (2014) claim the absence of any form of 'gold-standard' definition makes it extremely difficult for effective screening to take place.

A range of screening tools are regularly employed for assessment purposes in New Zealand. Any attempts to compare data between assessments or internationally should be undertaken with caution. Maynard and Paton (2012) highlight that the New Zealand health system has paid little attention to identifying hazardous drinkers at an early stage and even less consideration has gone into how to identify OAs with difficulties. The absence of a gold standard assessment tool in New Zealand would suggest this is true. This establishes a context of screening tools in New Zealand, which is considered in more detail below.

Assessment tools and practical considerations

The fourth aim of this study is to establish whether participants are aware of assessment tools for OAs and whether these are helpful in practice. Limited research has been undertaken on screening tools for OAs in New Zealand (Hodges & Maskill, 2014). The use of consistent assessment tools is important because if interventions are to be implemented successfully identifying amounts of drinkers experiencing harms at a community level is required (Towers et al., 2011). As discussed identifying OAs at risk is difficult as international estimates of alcohol prevalence rates vary, mainly due to screening tools being inconsistent (Towers et al., 2011), and designed for younger cohorts (Draper et al., 2014). Further, what is unknown is whether RSWs in New Zealand are aware of assessment tools and whether they are useful in supporting practice. Data regarding this question is presented in this study.

Using a consistent screening tool is important as it can provide a neutral environment for the social worker to ask questions regarding alcohol. However, Dance and Allnock (2013) found just because the question was on a form some social workers felt it did not give them the right to always ask, possibly feeling this was too intrusive.

Maclean, Gill, O'May and Breckenridge (2015) explored the beliefs and knowledge regarding OAs and alcohol use among occupational therapists in Scotland. Out of 122 participants none used standardised assessment tools for alcohol, with only 9% always asking about alcohol. This demonstrates a lack of data collection and consistency regarding OAs, alcohol within the allied health workforce in Scotland. This research gap was also noted by Shaw and Palattiyi (2008) who explored the perceptions of 18 social workers employed in an Older Person's Team in Scotland. The authors noted their research contributed to social work theory as there was little evidence of data gathered regarding social workers understanding of OAs and alcohol. Literature searches undertaken for this study have identified a similar gap in New Zealand.

Another way assessment may be achieved is by integrating alcohol questions into standard health assessments. Standard health assessment tools provide the means for consistent questions to be asked of anyone being assessed in a particular setting. Some evidence suggests including alcohol into standard assessment tools provides the ability to reduce OA alcohol consumption (Livingstone & Galvani, 2012). However, the challenge here relates to the socially constructed barriers identified earlier. Health professionals will frequently concentrate on a physical presentation, not considering alcohol as an underlying cause as OAs are not typically perceived as alcohol users (Wadd, Lapworth, Sullivan, Forrester, & Galvani, 2011). Whether New Zealand based RSWs, include alcohol in standard health based assessments is currently unknown.

Different levels of awareness and attitudes among health professionals regarding OAs and alcohol use and less than ideal assessment tools results in levels of harmful drinking not being well known (Gell, Meier & Goyder, 2014), This lack of knowledge combined with the influence of practitioner perceptions contribute to alcohol presentations frequently being missed (Maclean Gill, O'May & Breckenridge, 2015).

A number of formal assessment tools or frameworks can be used for assessing people and alcohol use (See Appendix 1). However, Paech and Weston (2009), remind the reader that screening tools designed for the identification of substance use for OAs have not been validated

for a New Zealand population. This thesis aims to identify whether agencies use screening tools when assessing OAs and alcohol and whether participants found them supportive.

Screening tools are designed to assess if people are using alcohol harmfully or have dependence difficulties (Tadros et al., 2015). Some traditional screening tools, utilised for assessing younger cohorts, may not be suitable for assessing OAs. Modern assessment tools are beginning to consider particular OA needs as part of assessment processes:

> "Several screening tools aimed specifically at older people have been developed, including the Alcohol-Related Problems Survey (ARPS); these may be more appropriate than generic tools which, as we have highlighted, do not always screen effectively for substance misuse problems" (DrugScope, 2014, p.12).

A summary of the main assessment tools: Alcohol Use Disorders Identification Test (AUDIT), AUDIT-C, CAGE, Diagnostic and Statistical Manual of Mental Disorders (DSM) IV and V, Alcohol Related Problems Survey (ARPS), CARET, InteRAI, Michigan Alcohol Screening Test (MAST), and the Short Michigan Alcohol Screening Test- Geriatric Version (SMAST-G) can be found in Appendix 1.

There is currently little solid data regarding screening for OAs and alcohol use in New Zealand, local based research is needed to have a better understanding of what is required (Hodges & Maskill, 2014). What must be understood is; currently there is a lack of consistency regarding assessment tools for OAs and alcohol used in New Zealand.

Also of relevance is the impact of practical considerations for this cohort. For example, attending home visits can be challenging for many Alcohol and Other Drug services due to caseload sizes and addiction clinics can be unwelcoming or even intimidating (Dance & Allnonck, 2013; DrugScope, 2014). Social workers need to ensure treatment facilities are culturally sensitive for the OA (Wadd et al., 2011). Many OAs may not even be aware of clinics in their areas or face practical barriers such as mobility and transport (Murdoch, 2014; Wilson et al., 2015). How work is undertaken with OAs can be a significant factor in its success, some form of group work with same age peers was found to be useful by Wadd et al. (2011).

Social work also has a role in challenging some of the wider held perceptions of the health system. In their studies Crome, Rao and Crome (2015) and Maclean, Gill, O'May and Breckenridge (2015) argue professionals from other health backgrounds also have negative perceptions of OAs. Social workers are ideally suited to undertaking work regarding alcohol and the OA (Livingston & Galvani, 2012). Supervisors need to create a culture where social workers feel confident to challenge wider systems and build collaborative practice across different professional groups and roles (Galvani, 2015).

As discussed earlier in this literature review the proportion of New Zealand's population over 65 years is increasing rapidly. This change will result in a need for increased amounts of training and education of more social workers who can work effectively with OAs. There is also a need for improved methods and tools for working with this population (Soniat & Micklos, 2011).

Relationship between assessment and treatment

While this research is firmly focused on assessment processes it is important to recognise the connection between assessment and intervention. As established, assessment is the starting point of a process that may lead to the allocation of resources, the identification of strengths as well as needs and possibly to an intervention that can positively impact a person's life.

Treatment options are not only dependent on the available resources but also on the assessment that has been completed. Assessors should start considering intervention options by gathering data that supports discussion regarding lifestyle changes and the reasons for those changes (Murdoch, 2014). To be effective treatment which commences at time of assessment, must be tailored to the individual (DrugScope, 2014). Some evidence suggests OAs are more adherent to alcohol treatment than younger counterparts (Wadd et al., 2011). Many OAs who develop difficulties with alcohol will not require the input of specialist interventions but will, like other age cohorts, benefit from interventions in primary health or other settings.

If intervention is to be successful assessors need to work effectively with OAs who may be feeling shame as a result of their alcohol use (DrugScope, 2014). There are clear indications that OAs are more sensitive to shame than younger counterparts, this in turn can lead to possible concealment of drinking and non-participation in interventions (Wadd & Galvani, 2013).

Villers-Tuthill et al. (2016) argue, how an OA perceives their age, and their sense of control over positive and negative aspects of ageing, will significantly influence health behaviours. Work at

positively affecting these perceptions starts at the education stage. Assessors need to be trained to undertake assessments by not using labelling terms such as ‘alcoholic’, and being able to build alcohol use questions into standard assessments that address other health related behaviours and presentations (Murdoch, 2014; Wadd & Galvani, 2014). For effective and successful interventions to take place assessors need to be considering alcohol related questions alongside other health issues, asking about alcohol in a manner than allows the OA to be honest and not feel they need to hide their use as a result of shame or guilt. Wadd and Galvani (2014), from their studies of UK based social work practitioners, claim the following basic requirements are needed: the building of rapport and development of skills and to be able to embed questions in the context of health behaviours. These basics results in assessments being undertaken successfully. No New Zealand evidence currently exists as to whether RSWs are able to complete this work, clearly highlighting the need for, and importance of this thesis.

Conclusion

This chapter has explored evidence and gaps in established literature in relation to the four aims of this research study. Part one explored and defined social work assessments, skills and particular requirements for effectively assessing the OA. Part Two explored assessment in regards to OAs and alcohol use. Health professionals’ knowledge of this area was considered, several gaps were identified concerning the lack of New Zealand research, particularly as applied to RSWs. The literature also explored social workers’ perceptions of OAs, considering how socially constructed images contribute to practice. While some overseas evidence was presented, there is a gap regarding New Zealand RSWs’ perceptions of OAs and alcohol use. This thesis presents data in regards to these issues.

Connections to training were explored within reasons for use, patterns of use, gender patterns and connections to injuries. There is currently little research from a New Zealand context of training undertaken by RSWs regarding the emerging health concern of OAs and alcohol use. Again, this thesis presents data in this regard.

Health promotion literature and information was explored and connections made to screening tools, addressing a further aim of this study; whether social workers feel supported by the use of formal screening tools. The issue of which screening tools are used was explored for its impact on outcomes, this is important in terms of social work knowledge and training. There are further gaps in New Zealand literature regarding: the impact of using assessment tools, whether RSWs

use approved tools or even whether RSWs in New Zealand are aware of screening tools designed specifically for OAs.

Screening of OAs alcohol use was explored in some detail connecting to the reasons health professionals ask or do not ask OAs about alcohol use. There was no direct New Zealand data indicating whether RSWs ask OAs about alcohol use, which is the first aim of this study. Different approaches to screening were considered for their effectiveness, again relating to social workers' knowledge and training. Assessment tools were considered in some depth, there was no local evidence available to indicate what training RSWs have received regarding assessment tools and whether they use them when asking OAs about alcohol use. Also considered was practical aspects of assessments. Finally, connections were made between assessment and intervention.

Little is known about how alcohol fits in the lives of OAs in New Zealand (Hodges & Maskill, 2014). Literature searches undertaken for this study indicate little is also known regarding whether RSWs ask OAs about their alcohol consumption, what perceptions RSWs may hold about OAs and alcohol, whether training has been received on this subject, or whether screening tools are utilised. This study explores the gaps raised in this literature review from the perspective of RSWs as participants in the hope of understanding the meaning and implications of them for working with OAs and alcohol.

Completing this literature review enabled the interview schedule to be complied with some confidence of ensuring the main topics were addressed in terms of data gathering. These issues are further considered in the next chapter which outlines the methodology used in completing this study.

Chapter Three: Methodology

Introduction

This chapter discusses the methodological approach, participant selection, ethical considerations, and data analysis of this study. The areas covered include: the reasons for the chosen methodology and methods; an overview of the participant selection process; an exploration of the ethical considerations; a discussion of the procedures used in analysing the participant data; and a conclusion which summarises the discussion. It should be noted all analysis was conducted manually.

This study explores participant views and understandings of the assessment of OAs and alcohol use, what influences the process of assessment and how improvements can be made. The four research aims of the study and key questions are as follows:

To establish if RSWs, who participated in this research, asked OAs about alcohol use. This aim is reflected in the research questions, such as: 'should OAs be asked about alcohol use? Why?' These questions were designed to gather an understanding of whether participants asked OAs about alcohol and the reasons they did so, setting the context for further exploration.

The second aim explored whether socially constructed perceptions of OAs contribute to and impacted on the participants' ability to assess alcohol use. A key question to meet this aim was: 'what perceptions do participants have regarding OAs and alcohol use and where do these perceptions originate from?' Impact of perceptions on practice are a significant feature of this study, interview questions explored participants understanding and awareness of this area.

The third aim concerned whether participants had undertaken training regarding OAs and alcohol use. For this aim a major research question was: 'what training in working with OAs and use of alcohol has been undertaken by the participants?' Currently no evidence exists regarding training levels for RSWs regarding OAs and alcohol in New Zealand.

The final aim was to establish whether agency assessment tools supported participants to ask OAs about alcohol use. A key research question regarding this aim was: 'what assessment tools do participants use, are they supportive and useful?' Also of importance here was the consideration of whether alcohol should be included in standard health based assessments. As part of this study was to explore what services needed to be in place, a key question here was:

‘what needs to be in place to improve services?’ These questions looked to plan a way forward to improvement.

See Appendix 7 for a full schedule of questions.

Methodology and methods applied

This section explains the reasons for the use of the selected methodology and methods in this study. Learning the difference between these two terms was part of this project. In its simplest form, Clough and Nutbrown (2012) explain methods are the ingredients of research while methodology is the reason for using a particular research recipe.

A qualitative methodology was pursued as the subject explored was relatively unknown and needed to be considered in ‘real life context’. Influences on this selection were an interest in exploring meanings rather than measures (Braun & Clarke, 2014) and the participants’ own framing of the issues of social constructivism and ageism; Braun and Clarke (2014) claim a qualitative methodology is best suited to this work. Similar international studies provided sound reasoning for selecting a qualitative approach. For example, Waldron and McGrath (2012), employed a similar approach when gathering data regarding OAs and alcohol from allied health workers in Eire. Likewise, Wadd and Galvani (2014) when exploring the issue of OAs and alcohol use selected a qualitative approach, because very little was known about complex attitudes surrounding the subject, providing justification for use of this approach.

Since in-depth feelings and attitudes of participants based in New Zealand were to be explored, grounded theory method (GTM) was selected as the means of gathering data and developing relevant theory to address the main research question. Charmaz (2014) explains GTM is a set of flexible, yet systematic guidelines that support a researcher in gathering, comparing and analysing data to construct theories emergent from the data. This approach was considered appropriate as assessment, detailed previously, is considered part art and part science.

GTM has two main original approaches; positivism and pragmatism. Charmaz (2014) however, favoured a constructivist approach, considering GTM as a constellation of methods, rather than a range of different methods. Charmaz (2014) also identified a range of strategies for employing GTM which were useful in this study: undertake data collection and analysis as an iterative process, analyse actions and processes not themes and structure, comparative methods should

be used, develop analytic categories, keep focus on theory construction not application of current theories and theoretical sampling should be part of the process.

Ensuring qualitative methods gather useful data can be challenging, creativity with approach is required (Creswell, 2013). Semi-structured interviewing uses a flexible structure, allowing the interviewer to follow the natural flow of the conversation (O'Leary, 2010). The subject matter of this study necessitated an approach that allowed the interviewee the opportunity to explore feelings and reasoning. Methods in human science research are open ended and ethically participants should be provided an opportunity to explore their beliefs in regards to the subject matter (Moustakas, 1994). For example, Shaw, and Palattiyil (2008) used semi-structured interviews with thematic analysis when exploring the attitudes and perceptions of social workers in regard to consumers' alcohol use in an Older Person's team in Scotland. This approach led to a range of themes identified and findings grouped in such a way as to make access easy.

A 'face to face' approach is the 'Gold Standard' of interviewing and was used in this study because it allowed the interviewee the freedom to express their thoughts (Braun & Clarke, 2014). The interview questions were designed so participants were able to fully explore the subject as well as the interviewer gather data regarding the four aims of the study. The questions were not strictly ordered under each of the four headings so there was opportunity for participants to explore additional areas of interest and for the interviewer to be able to respond to matters that were raised by the participants during the interview.

Some explanation is required as to a framework for questions. According to Clough and Nutbrown (2012) four types of questions are required to complete a research project. Firstly, researchers must ask themselves personal questions regarding their location within the research and drive for undertaking it. In this instance awareness of "positioning" and of how personal and professional experience can impact research. Interest in the area of OAs and alcohol use was developed while working in a Mental Health and Addiction service role, covered earlier.

Secondly, careful consideration of questions is vital to the success of a research project. In this instance this includes not only the main research question, or topic for exploration but the four aims of this study. A focus on social work assessment of OAs and alcohol use was selected as the subject is increasingly discussed by several social work authors (Cooper, 2012; Cummings,

Bride, & Rawlins-Shaw, 2008; Wadd & Galvani, 2014), indicating the subject is current and discussed within the profession.

Thirdly, field questions require planning in partnership with data analysis, since they control how successfully data will be gathered. In this instance, they were designed to gather the data required to answer the four aims of this study.

Finally, ethical questions are a part of all other questions and sections of a research project. For this project these questions are covered in depth below in the Ethics section.

Participant selection

This section concerns the manner in which participants were recruited and selected. According to Newington and Metcalfe (2014) participant selection is important for ensuring valid results are achieved. A range of RSWs, in terms of both practice diversity and length of experience, were able to be recruited. Being able to compare a range of subject material, supported diversity of data gathered (Flick, 2011).

A purposeful method of participant selection was employed, targeting participants meant the issue could be explored in depth (Flick, 2011). The selection method commenced with an email being sent via the SWRB to all RSWs in a large urban area in the Lower North Island. This email contained details of the proposed study, explanation of participant criteria, interview questions and details of how to contact the researcher (see Appendix, 3, 4 and 5). Potential participants needed to meet defined criteria: RSWs who have assessed an OA's needs, there was no time limit on when this had taken place, enabling a greater range of potential participants to be contacted. There was also no required length of time for registration, because a mixture of experience was useful for producing a range of views. All participants had to be able to conduct an interview in English and finally, needed to work within the required urban region in the Lower North Island.

Potential participants self-selected themselves by contacting the researcher directly by cellular phone or email. There was some evidence of a 'snowball' effect (participants contacting other potential people and applications gathering momentum as a result) (O'Leary, 2010). A social work leader within the required region contacted the researcher to participate and disseminated the information among her team encouraging RSWs to also participate. Two study limitations should be highlighted at this point. Firstly, the snowballing effect resulted in five participants

having worked at some point in the same regional hospital (four currently, one had left). All participants worked on different wards, and held different roles, within a mid-sized District Health Board. The second limitation to note is this study was situated within secondary health, there were no participants working in a primary health setting at time of interview. This set a clear context for data gathered and recommendations made.

Eight potential participants contacted the researcher, all met the required criteria and were interviewed over a period of six weeks. This scheduling allowed time to reflect between interviews and consider what issues to pursue moving forward. All eight interviews took place at the RSWs work place and ranged in duration from 45 to 75 minutes. All participants showed a commitment to and passion for the subject matter, with all appearing to be genuinely interested in making improvements for OAs and how services are delivered. There was a mixture of participants, from physical and mental health, older adult rehabilitation and medical wards. One participant was working as an occupational social worker and one was in a leadership role, all but one were female. The interviews, with the participant's permission, were recorded and transcribed, following the Information Sheet (Appendix 5).

Employing a purposeful selection ensured participants had enough experience, education and understanding of OAs. Post-graduate experience increased confidence in discussing the subject. Newington and Metcalfe (2014) argue participation numbers are vital to the success of a research project, with access to suitable participants an important consideration. The subject matter of this research appealed to a number of RSWs suitable to complete the requirements of a qualitative Masters level study. Participants presented as honest, trustworthy and passionate regarding the subject matter. GTM afforded the opportunity to compare data with data and in turn with established literature, creating outcomes from triangulation.

Ethics

This section presents considerations regarding ethics and includes: the impact of making an application to Massey University Human Ethics Committee, considerations for protecting participants and safeguarding of recorded information.

Ethics is not only about research achieving sign off from an ethics committee, but also consideration of a range of ethical issues that may come up at any point in the project (Creswell, 2013). In this instance a successful application was made to Massey University Human Ethics

Committee (See Appendix 2). The application covered the research process and was made as the student had limited experience of undertaking research with human participants. The Ethics Committee raised two issues for consideration:

Firstly, the committee asked for further detail with regard to the qualitative methods that would be used to analyse the data, in particular details of how the required level of analysis would be completed were requested. Details of approaches to be used and means of analysis were provided.

Secondly, information of what might happen in the event of a social worker disclosing negligent practice was requested. How would such an instance be managed? Details regarding how any concerns would be managed were provided.

These two requests provided an excellent opportunity for reflection on areas the researcher had not considered in enough depth; both were addressed prior to attaining ethical approval. The first required further reading and consideration as to how coding and analysis would be undertaken and discussion with supervisors. The second required familiarisation with required University and SWRB policies, and again discussion with supervisors.

Throughout the process participants' rights needed to be protected. This was achieved by fully informing participants of the nature of the research, the aims of the study and the rights of all who took part. To ensure this was covered from the beginning an information letter and consent form were developed (See Appendix 5 and 6). These covered participant rights to withdraw and to have their identity protected. All information conveyed was done in a manner that ensured compliance with Code of Ethical Conduct for Research, Teaching and Evaluations involving Human Participants (Massey University, 2015). Participants were asked to sign a consent form (Appendix 6) and a release form for data gathered to be used (Appendix 8).

Transcripts were sent back to all participants via email, participants were asked to read and provide feedback. This feedback was managed sensitively due to risks of offending participants. Recordings and findings were presented in a way that protected participants from being identified by providing each person with a pseudonym and not disclosing the specific details of their employment, meeting the requirements of the Code of Ethical Conduct for Research, Teaching and Evaluations involving Human Participants. (Massey University, 2015). All recordings were stored safely with only the student and supervisors having access.

Some ethical considerations needed to be considered for the interviews. For example, participants as interviewees may have felt a conflict of interest, possibly questioning whether the interview was focused on their own practice, or on their organisation's performance. Particularly as some questions were around agency tools employed for assessments. This issue was made clear to interviewees so they could feel relaxed enough to talk from their own perspective. For participants to talk freely, assurances of confidentiality were offered with a caveat of needing to share any information that suggested people may be at risk or of course, as directed by the Ethics Application, any evidence of inappropriate practice.

There were a range of ethical considerations to be managed as covered above. This did not end with approval from an ethics application. Participants needed to feel relaxed with a clear understanding of any implications from their involvement. The quality of data gathered indicates the process of ensuring participants felt safe was successful.

Data Analysis

This section explores how data gathered from participant interviews was analysed. As established above a GTM approach was employed as being most suitable for this study. This section presents the data analysis in stages: firstly, completion of open coding, secondly, the selective and theoretical coding, thirdly, saturation of data.

Open Coding

Open coding is the first step of analysing data using a GTM approach (Urquhart, 2013). The open coding method chosen followed Urquhart's (2013) and Charmaz's (2014) method of 'line by line coding', resulting in data being analysed rather than simply described. Each transcription was analysed line by line, resulting in many different open codes being identified. Coding is the important link between gathering data and constructing a theory (Charmaz, 2014). Table 3.1 (page 45) provides an example of open coding used at this stage.

As advised by Charmaz (2014) coding was kept simple, direct and spontaneous as open coding should not be complex. Charmaz's (2014, p.120) 'code' for coding was useful: the researcher should remain open, should stay close to the data, should keep codes simple, short and precise, compare data with data (triangulation) and finally move through data quickly. Other useful advice was also considered; study the emerging data (Glaser,1978) and undertake open coding by using a psycho-social process focussing on what participants describe themselves as

doing (Foley and Timonen, 2015). Using these approaches enabled a move to a more selective method of coding by using the most significant or frequently identified codes.

Table 3.1 Open coding example

Participant comments	Open coding
I was being an adult. His son was present so I said the Doctors are very concerned about your drinking	Alcohol use medical responsibility
and you know it's going to affect your brain over time, it's going to affect your liver,	Alcohol impacts negatively on health
I didn't actually think he was drinking, but I didn't feel it was safe for him to go home	OA not see as alcohol user
I felt that for whatever reason his cognition was way off.	Uncertain reason for confusion
This was a guy who was an electrical engineer so a highly-educated gentleman.	High education so doesn't use alcohol?
Interviewer: Did he find it difficult to talk about it?	
No, no but you find a lot of it is all about denial and minimisation. You know deny, deny, deny.	Perception is around denial for OAs
At the end of the day I didn't think he was a drinker	OA not seen as alcohol user

During these early phases of coding it was important to remain open to all possible theoretical directions (Charmaz 2014). Awareness developed of comparing codes with codes (triangulation of data) and of beginning to undertake basic theoretical sampling. According to Charmaz (2014) when a researcher engages in theoretical sampling they seek statements, events or cases that illuminate categories. This work progressed into a selective coding phase.

Selective Coding

While the open stage of coding begins to generate the bones of a research project, selective coding is the stage where codes are identified that relate to the core category (Charmaz 2014; Glaser 1978). Urquhart (2013) clarifies this further; at this point the focus is on the main subject of the study, in this case; older adults and alcohol: a study of registered social workers' assessment practices.

The main research topic was supported by the four underpinning aims of this study, being: firstly, to establish whether RSWs ask OAs about alcohol use, secondly, to explore whether socially constructed perceptions of OAs contributes to participants' ability to assess alcohol use of OAs, thirdly to establish training levels regarding OAs and alcohol use and finally, to establish whether agency assessment tools support the participant to ask OAs about alcohol use.

Identifying four main aims had connections to Glaser's (1978) using of coding families for analysis. Glaser's (1978) approach came under some criticism, for example by Kelle (2007, p. 200) for having too many 'assumptions that are not made explicit' and therefore limiting usefulness for structuring selective coding, especially for beginning researchers.

Another area of challenge with selective coding is abstraction. To be workable a theory only requires a few constructs or core categories, whereas resulting from richness and depth of analysis, GTM can have many (Urquhart, 2013). Awareness of coding as an iterative process was required; considering codes, debating their meanings and relationships.

Urquhart's (2013) framework offered above became the approach selected for moving from open coding into selective coding. Firstly, all open codes from the first transcription were copied and pasted into a word document. These were then numbered, the first interview producing 103 different codes. These were further placed into groups or 'coding families'. Where a code was identified more than once it was only entered once. Those codes with no relevance to the process (clarifying questions for example) were removed, this process was followed a number of times to ensure selective coding results were pulled into manageable groups.

The stages suggested by Urquhart (2013) namely: group selective codes together, consider if one selective code is an attribute of another, consider if a selective code is a relationship to another, consider if any of the open codes in a selective code are a better name for that selective code and consider if the name you have given to the selective code is truly representative, were followed resulting in five selective codes. These were: impact of assessment processes, impact of alcohol use, professional and personal experiences, importance of relationship building and perceptions of OAs and alcohol. On reflection, there appeared some connections between the four aims of this study and the resultant selective coding, demonstrated in Table 3.2.

Table 3.2 Selective coding results from interview of participant one

Selective Code	Study Core Aim
Impact of assessment processes	Establish whether RSWs ask OAs about alcohol use. Assessment impact covers whether participants ask OA about alcohol use. Establish whether agency assessment tools support the participant to ask OAs about alcohol use. Use of assessment tools impacts on whether OAs are asked.
Impact of alcohol use	
Professional and personal experiences	Establish training levels regarding OAs and alcohol use. Training is about Professional experiences.
Importance of relationship building	Explore whether socially constructed perceptions of OAs contributes to participants' ability to assess alcohol use of OAs
Perceptions of OAs and alcohol	Explore whether socially constructed perceptions of OAs contributes to participants' ability to assess alcohol use of OAs.

At this stage the focus was on looking at selective codes that pointed the way to future theoretical sampling (Glaser, 1978). However, other considerations were also relevant. This was the first attempt at coding, it's possible that a basic feature of GTM was not followed. Urquhart (2013, p.4) reminds us a basic consideration of GTM is to "Set aside theoretical ideas in order to let substantive theory emerge", or more famously by Strauss's (1978) claim that there exists a difference between an open mind and that of an empty head. The researcher needed to ensure they remove themselves from established reading and theory identification for the process to be valid. A connection here should be made between inductive and deductive approaches to research. Inductive reasoning is rather open-ended and exploratory, whereas deductive is a narrower approach, such as testing a hypothesis. In most pieces of social research, like this one, both of these approaches are present at some time (Trochim, 2006). At this point, further coding was required.

Interview two, with a mental health leader, was in more depth resulting in a wider range of codes demonstrated. The selective coding outcomes for this data were significantly different to those of the first one but with clear connections between selective coding patterns. These

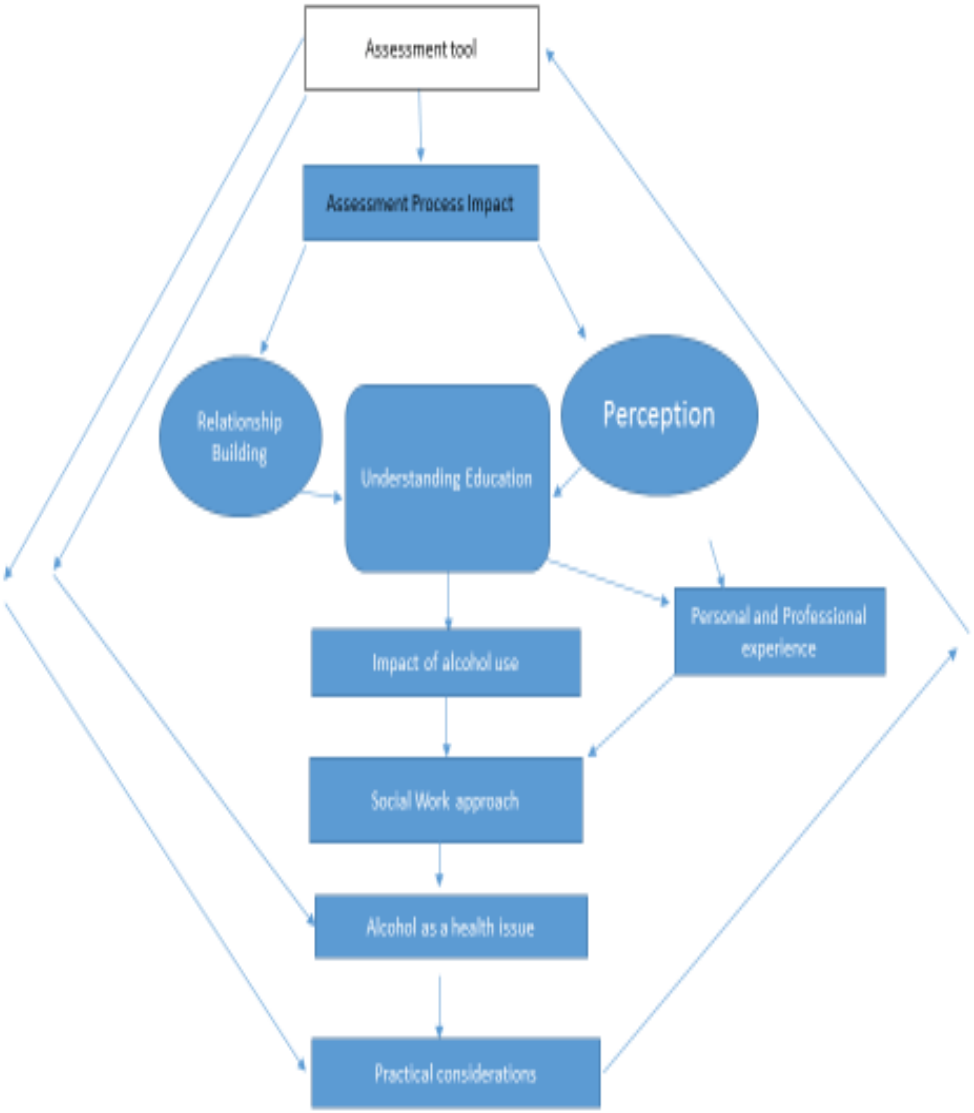
connections are displayed in relation to each other, and in context of overall study aims. From these early interviews it became apparent participants' perceptions of OAs as a group impacted on outcomes, this is demonstrated in Table 3.3. Also, added at this point was an Additional Issues section, this was for data sitting outside the four aims.

Table 3.3 Selective coding results from first two interviews

Core Element of study	1st Interview	2nd Interview
Establish whether RSWs ask OAs about alcohol use		Assessment Process Impact
Establish training levels regarding OAs and alcohol use	Professional and personal experiences	Social work approach important for results Education, understanding and experience around subject
Explore whether socially constructed perceptions of OAs contributes to RSWs ability to assess alcohol use of OAs.	Importance of relationship building	Perception of OAs and alcohol
Establish whether agency assessment tools support the RSW to ask OAs about alcohol use.	Impact of assessment processes	Assessment tool
Additional issues highlighted	Impact of alcohol use	Alcohol as health issue Practical considerations

As described by Charmaz (2014) undertaking line by line coding enabled the data to be studied in detail, within each fragment. Strauss (1987) highlights the use of what he terms integrative diagrams to aid this understanding. These diagrams change over time, at this early stage an Integrative diagram of this process is presented as 'Figure 1: First stage of reflections' on page 49 below. This figure provides a good illustration of data collected and analysed to this point. It displays thinking in terms of the starting point for any consideration being the assessment tool, however the journey from that point can either follow a process of the participants' knowledge and perception or can move directly to considering alcohol as part of a health concern and practical consideration. At this point the thinking was very linear, with little awareness of any interconnectedness within this study.

Figure 1: First stage of reflections



From this point onwards awareness of the many connections and interrelationships between different categories became relevant. Many codes were overlapping, with too many similar categories. While undertaking analysis on the third interview and considering the relationships between codes and categories Spradley's (1979) reflection guide on current selective coding was used: Is it a kind of? Is a part of? Is it a way to? Is it used for? Is it a reason for? Is it a result / cause? And is it a characteristic of?

The third interview, of a social worker experienced in District Health Board Rehabilitation work, impacted on the consideration of selective coding groups and therefore further impacted on categories selected. Table 3.4 (page 51 below) displays results which indicated some codes were not required due to being too overlapping in detail.

This work resulted in the importance of 'relationship building and professional and personal experiences' being incorporated into other codes. This required further reflection, while recognising that 'professional and personal experiences' could form part of 'education, understanding and experience around subject', 'importance of relationship building' needed further consideration. The perceptions of OAs continued to feature highly in responses to questions regarding decision making, beginning to take on a central theme.

At this point awareness developed of different issues being explored as interviews progressed, several subjects had been added into the questions asked: Gender balance- more males or females seen? Rapport building- how important is this in terms of interviews? What impact does shame experienced from drinking have? What impact do perceptions have? Is it difficult to talk to OAs about drinking? These additional questions enabled extra areas of data to be gathered, clearly impacting upon coding.

Urquhart (2013) clarifies during the course of a GTM based research study a researcher's idea of the question may also develop. A significant factor absent from the first interview coding was that of practical considerations, becoming a key feature from the second interview onwards. Practical considerations covered a range of issues such as referrals to other services, transport issues, community work and privacy issues. While not sounding particularly exciting this code had overlap with, and influence on, many others.

Interview four was coded without a huge amount of new data being gathered. One notable aspect was a continued increase in the recording of 'perceptions of OAs and alcohol'. Interviews 5 and 6 were important in that they brought up new concepts that enabled reflection on the subject being researched. The first of these was the concept of judgement. This was in relation to participants being judgemental and of OAs feeling that they were being judged.

Table 3.4 Selective coding results from interview of first three participants

Core Element of study	1st Interview	2nd Interview	3rd Interview
Establish whether RSWs ask OAs about alcohol use		Assessment Process Impact	Assessment Process Impact
Establish training levels regarding OAs and alcohol use	Professional and personal experiences	Social work approach important for results Education, understanding and experience around subject	Social work approach important for results Education, understanding and experience around subject
Explore whether socially constructed perceptions of OAs contributes to RSWs ability to assess alcohol use of OAs.	Importance of relationship building	Perception of OAs and alcohol	Perception of OAs and alcohol
Establish whether agency assessment tools support the RSW to ask OAs about alcohol use.	Impact of assessment processes	Assessment tool	Assessment tool
Additional issues highlighted	Impact of alcohol use	Alcohol as health issue Practical considerations	Alcohol as health issue Practical considerations

It also became apparent there was overlap in selective codes and some of the codes were being perceived differently. The main example of this was: ‘alcohol as a health issue’. This had started the process as a means of capturing when and how alcohol was imbedded into health

assessments as a standard approach. However, what was being recorded under this code was more health impacts of alcohol. Given the overlap the consideration was to remove ‘alcohol as a health issue’, but doing that would have meant losing the opportunity to see if participants ask about alcohol during general health assessments- this had been made clear in interview one. Instead of merging, the decision was to rename ‘alcohol as a health issue’ to ‘alcohol as a standard item in health assessments’. This was an in vivo code from interview one. Charmaz (2014) provides three explanations for in vivo codes: general terms that flag significant meaning, codes that can be participants’ innovative terms capturing meaning or experience or insider or short hand terms. Time was another in vivo code as this was directly mentioned by over half of the participants as being an impact on the assessment process.

‘Alcohol as a standard item in health assessments’ meant participants identified alcohol should be part of standard health assessments. Up to this point of coding all participants (6/6) had indicated alcohol should either be part of standard assessments or should be added to general assessment forms. In contrast ‘perceptions of OAs and alcohol’ remained a central theme, but also appeared a reason for not asking about alcohol.

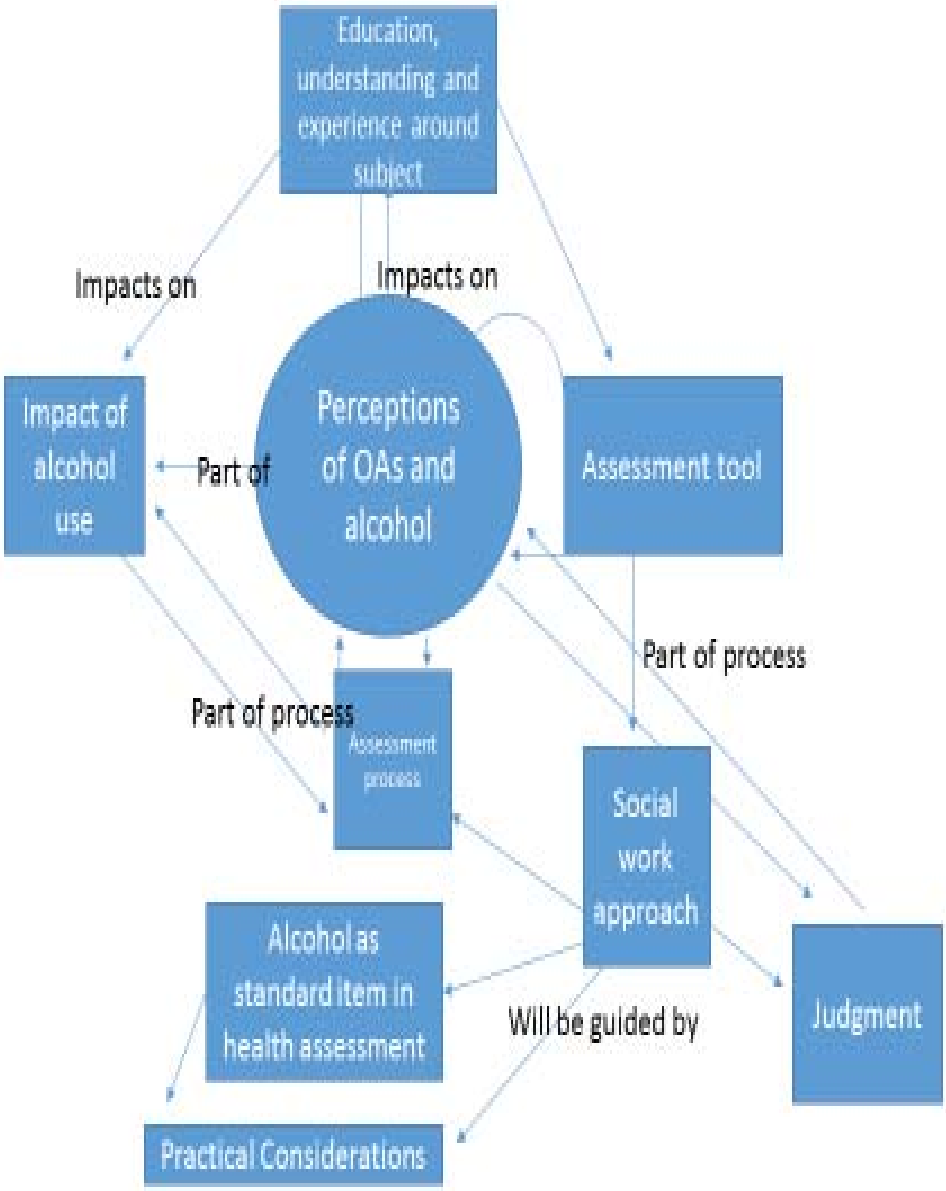
This work resulted in a further selective coding table. This is displayed as Table 3.5 on page 53 below.

These changes warranted the construction of a further integrative diagram, ‘Figure two: Second stage of reflections’ (see page 60). The major change in this diagram was establishing ‘perceptions of OAs and alcohol’ as the hub around which other items circulated. Sitting above and influencing all other codes is ‘education, understanding and experience of subject’, this code has the potential to influence all others, however as depicted ‘perceptions of OAs and alcohol’ can impact on this code if allowed.

Table 3.5 Selective coding results after six interviews

Core Element of study	Selective Codes
Establish whether RSWs ask OAs about alcohol use	Alcohol as standard health assessment Assessment Process Impact Subcode: time
Establish training levels regarding OAs and alcohol use	Social work approach important for results Subcode: Judgement Education, understanding and experience around subject
Explore whether socially constructed perceptions of OAs contributes to RSWs ability to assess alcohol use of OAs	Perception of OAs and alcohol Education, understanding and experience around subject
Establish whether agency assessment tools support the RSW to ask OAs about alcohol use.	Assessment tool Impact of alcohol use
Additional issues highlighted	Practical considerations

Figure 2: Second stage of reflections



Further coding of the remaining two interviews continued to develop thinking, much open coding was becoming far too descriptive and so required further analysis. Evidence of perception becoming a huge component continued to develop. This was not as seen earlier, in regards to OAs and alcohol use, but more simply in regards to 'perceptions of OAs'. Alongside judgment came a consistent subcode; shame. Codes began to emerge that indicated a circular pattern was developing. 'Assessment process impact' was reconsidered in light of new data, this appeared to be incorrectly coded- 'impact on assessment process' better fit the evidence. Once re-named it became clear this code was interrelated with most other codes identified. An example of factors that impacted on assessment process was the subcode of time. Participants highlighted there was not enough time to undertake assessments regarding alcohol. An in vivo subcode of intrusiveness was identified with participants feeling asking OAs about alcohol can be seen as intrusive therefore affecting the assessment process. Table 3.6 (page 56) demonstrates these new insights.

The next stage of work was progressing through to theoretical coding. The stages completed until this point; "Conceptualise the empirical substance of the area of research" (Urquhart 2013, p.107). Theoretical coding however moves this further as it enables the researcher to "Conceptualise how the substantive codes may relate to each other" (Urquhart 2013, p.107). Glaser (2005) warns against 'forcing' a theoretical code on the data, particularly if the researcher has read widely and may have theoretical patterns in their head. Such work would move the process away from an inductive approach by forcing the theory in a particular direction (Urquhart, 2013). The theoretical approach developed by this work resulted in the following concept:

Participants responded to their own perceptions of the OA, not considering OAs as alcohol users, needing to be formal, to respect / not be judgmental. To therefore reduce shame, and be less intrusive. To achieve this, participants did not pursue questions regarding alcohol despite recognising alcohol should be part of standard health assessments. A framework to place around an improvement for this process is:

Perception→ Perceived respect→ Shame / intrusiveness →Standard Health assessment question.

This study has termed this emerging model; 'perception to standard question' approach.

Table 3.6 Selective coding results after eight interviews

Core Element of study	Selective Codes
Establish whether RSWs ask OAs about alcohol use	Alcohol as standard health assessment Subcode: time Subcode: Alcohol often missed Impact on Assessment Processes Subcode: Intrusive
Establish training levels regarding OAs and alcohol use	Social work approach important for results Subcode: Judgement Subcode: Shame
Explore whether socially constructed perceptions of OAs contributes to RSWs ability to assess alcohol use of OAs.	Education, understanding and experience around subject Perception of OAs
Establish whether agency assessment tools support the participant to ask OAs about alcohol use.	Assessment tool Impact of alcohol use
Additional issues highlighted	Practical considerations

Saturation of data

Saturation is not about seeing the same patterns again and again but rather about comparing different patterns of data and not yielding new properties (Chamaz, 2014). In other words while comparing different codes no new patterns emerge or when comparing data no new theoretical insights are gained.

In this instance eight interviews appeared to reach saturation point with similar themes not leading to new information. The data was continually analysed, to the point of being able to pull together a cohesive findings chapter. Table 3.7 presents the final codes used.

Table 3.7 Final selective codes

Core Element of study	Selective Codes
Establish whether RSWs ask OAs about alcohol use	Alcohol as standard health assessment Subcode: time Subcode: Alcohol often missed Impact on Assessment Processes Subcode: Intrusive
Establish training levels regarding OAs and alcohol use	Social work approach important for results Subcode: Judgement Subcode: Shame Education, understanding and experience around subject
Explore whether socially constructed perceptions of OAs contributes to RSWs ability to assess alcohol use of OAs.	Education, understanding and experience around subject Subcode: Drinking patterns Perception of OAs Subcode: trust
Establish whether agency assessment tools support the participant to ask OAs about alcohol use.	Assessment tool Impact of alcohol use Subcodes: Positive / negative / injuries
Additional issues highlighted	Practical considerations Subcode; Access to services

Conclusion

This chapter has provided justification for methods employed while completing this research. Question design was considered and discussed as was the chosen qualitative approach of

GTM. GTM afforded a flexible and in-depth data gathering approach suitable for exploring feelings and attitudes. The methods employed were face to face semi-structured interviews and detailed coding during analysis. Participant selection and the criteria for targeted selection were also described.

Ethical issues were considered and processes put in place to mitigate any impact. The strongest part of this chapter is the detailed data analysis section, displaying the different stages of the processes undertaken. The next section presents the findings from the participant interviews. It builds on the context set by the Introduction, the evidence provided within the Literature Review and the process itself described in the Methodology.

Chapter Four: Results

"No one wants to ask their Granddad or Dad about alcohol"

Introduction

This chapter presents the findings from the participant interviews. An overview of the participants' backgrounds is provided first, followed by a narrative account of the interview data gathered. Interviews were conducted using open ended questions related to the four aims of this study. Participants were prompted to add detail or clarify answers. Some data led to further questions being developed.

The data is categorised into seven areas relating to the four aims of this study. These are the impact of participants' perceptions on assessment; participants' education and knowledge regarding OAs and alcohol use; the impact of alcohol as part of assessment processes; social work approaches as part of the assessment process; participants' views about alcohol as part of standard health assessments; participants' use and knowledge of assessment tools; and the impact of practical considerations on assessments.

Three significant themes are interwoven throughout all of the findings. These are also highlighted in the chapter's conclusion. They are: a) participants' perceptions of OAs regrading appearance, being a cohort with similar needs and behaviours, b) alcohol is not seen as a social work responsibility and c) there is a need for education and training.

Many sections in this chapter are connected and impact upon each other. This connectedness is an important aspect of this study because it demonstrates the way that social work assessment itself is a combination of the assessor's skill, the interviewee's contributions and the environment – all of which impact on each other. Different parts of an assessment process will be linked and relate to each other. This complexity and fluidity is captured in the methodology used.

Participants

The participants were all RSWs recruited from the lower North Island region. Most were registered for more than five years and all bar one were female. Their ages ranged from one participant in her 20s through to several in their 40s. All had experience in social work in health

system settings where they undertook assessments of OAs. Most had direct experience of assessing OAs' alcohol use. Further details of their backgrounds are displayed in Table 4.1.

Table 4.1 Participants details

Study Name	Gender	Age	Time registered	Background
Kelly	Female	40s	9 years	Experience of assessing OAs in community, mental health and rehabilitation settings
Trudi	Female	40s	7 years	Lead Mental Health social work role. Experienced in assessing OAs on medical wards
Tarren	Female	40s	8 years	Experienced assessing OAs rehabilitation needs
David	Male	40s	9 years	Mental health and medical ward assessment experience
Susan	Female	30s	5 years	Mental Health and ED / Medical Assessment and Planning Unit experience
Nellie	Female	30s	6 years	Community based OAs assessment experience
Lucy	Female	40s	3 years	Health social work assessment role
Donna	Female	20s	6 years	Experience of assessing OAs on medical wards

The impact of perceptions on assessment

The participants' perceptions of OAs is a central theme of this study appearing throughout these findings. This section explores participants' perceptions concerning OAs appearance, OAs being seen as all the same, the origins of our perceptions, prying / respect and the extent of impact on assessments these perceptions have. This section links clearly to the second aim of the study; to explore whether socially constructed perceptions of OAs contributes to participant ability to assess alcohol use.

The participants reported various perceptions of OAs. The most unexpected of these was the way appearance, described by participants as how an OA appeared as opposed to their speech or demeanour, impacted on participants' decision making. For example, Trudi explained; "*I*

would have a preconceived idea of the middle class woman who's doing really well, you have a preconceived idea whether that person will drink or not". Trudi held onto these perceptions despite her background in mental health where she learnt; *"Everyone can have issues with alcohol and so it can be more hidden behind those preconceived ideas".* Trudi's perceptions influenced her decision making, despite her knowing these perceptions may be incorrect. Similarly, Susan also had perceptions that impacted on her decision making; *"You know, lip stick, nice dresses, those are probably the one's that drink the quite well off, not the poor".* Susan elaborated about how her decisions to ask OAs about alcohol were influenced by personal appearance. She commented that she always asked women who looked like her Grandma (who was a heavy user) about their drinking. Appearance had a significant impact on whether some participants asked OAs about alcohol use, indicating that the effectiveness of an assessment can be very reliant on the assessors' perceptions of OAs.

Some participants' practice was directly affected by their perception that all OAs behaved in the same way. For example, Tarren held clear perceptions of OA behaviours regarding alcohol use; *"You just don't think of them drinking, well I don't anyway*". Trudi further explained, "*They present really well and really nicely, I guess you think of older people and your own grandparents, old people who play with kiddies, they don't go out to pubs or clubbing anymore"*. Susan's perceptions of OA behaviours focused on another aspect of alcohol use; "*I know most of them don't have what we would call hangovers"*. Someone had told her this was the reason OAs, *"Have another drink, you know hair of the dog".* Overall these examples demonstrate how the participants saw OAs as a cohort of people with the same needs. This impacted on their practice because they assumed that these behaviours were common to all OAs, thereby being less likely to identify alcohol difficulties where they existed. Age itself was a clear factor with Susan stating; *"I shouldn't pry 'cause there're older".*

The participants identified a range of origins for their perceptions. For example, according to Tarren, the origin was, *"ageism, [because] everyone assumes you get to a certain age, stop drinking and look after yourself".* Trudi felt her perceptions came from TV which informs us that OAs are respectable, but also from her personal experiences. Reflecting upon the origins of her perceptions Susan contradicted her views (expressed above) about the well-dressed OAs being those who drink, stating that perceptions from her childhood meant she would only ask OAs about alcohol who appeared, "*unkempt*". David felt his positive views of OAs originated from spending time with his grandparents when young. Overall, despite the participants showing an

awareness of the origins of their perceptions, these views of OAs still influenced decision making.

Susan demonstrated the extent of the impact of perceptions on her practice by claiming she knew a particular OA had difficulties with alcohol by looking at his nose and that it's possible to tell how much an OA has drunk by looking at their eyes. Later in her interview after reflecting upon the impact of her perceptions on her practice, Susan announced, *"The more I think about it maybe I haven't been asking the right people".* Lucy summed up the extent perceptions had on her practice in two ways, firstly commenting, *"No one wants to ask their Grandad or Dad about alcohol",* demonstrating her own personal impact. The second point concerned how male OAs were often overlooked as problem drinkers. Regarding this point she said; *"They are definitely missed because the old soaky type of men that sit in pubs, I don't think they are spotted as problematic alcohol users but they are".* The idea of needing to respect OAs by not asking about alcohol was a feature of several participant interviews.

Decisions about assessing for alcohol harm were markedly impacted by perceptions around their appearance and behaviours, coupled with a reluctance to ask in case it is seen as 'prying' or as a result of perceived similarities with older relatives. The implication of this on practice was a reliance on assumptions, initial data gathered and an apparent confusion of respect with a reluctance to assess. Paradoxically, even when participants were aware their perceptions were ageist or incorrect they were still influenced by them in their decisions regarding who should be assessed for alcohol related difficulties. In short, the participants' decision making was shaped more by their personal values than evidence or their professional knowledge.

The way participants perceived OAs was a central theme from the interviews and impacts upon many of the following sections.

Education and knowledge regarding OAs and alcohol

This section presents findings about the education completed by participants and their knowledge regarding OAs and alcohol use in three main areas: 1) OAs reasons for drinking, 2) gender differences and 3) recommended safe drinking levels. This connects with the third aim: establish participants' training levels regarding OAs and alcohol use.

Reasons for OAs alcohol use

Both negative and positive reasons for OAs' alcohol use were identified by the majority of participants, these are summarised in Table 4.2 (page 69) and are discussed in narrative form below.

Table 4.2 Reasons for OAs' alcohol use

Participant	Negative reason for use	Positive reason for use
Kelly	Loneliness, addiction, boredom, mental health difficulties	
Trudi	Lifetime of use, loneliness,	Drinking with friends
Tarren	Long term use, grief and loss, self-medicating	Social reasons
David	Loneliness, self-medicating (sleep)	Enjoyment, social reasons
Susan	Loneliness, want to die (remove self), grief, retirement, lifelong habit.	Enjoy taste, retirement
Nellie	Same as other cohorts, habit, to sleep, grief and loss (changes)	Enjoyment
Lucy	Marriage break up, habit, retirement and money	Retirement and money
Donna	Events, habit, retirement, culture, loneliness, boredom	Events, retirement, culture

The majority of participants were able to identify positive and negative reasons for OA alcohol use. While participants were asked for reasons for use, they were not prompted to elaborate. Some reasons appeared to be both positive and negative. All eight participants listed more negative than positive reasons for use, demonstrating their knowledge and understanding in this area. Loneliness featured in the majority of responses. Habit / addiction and long term use featured in nearly all responses.

The participants saw routines as an important reason for use. For example Trudi explained, *"It comes out when you're talking about what their routines are, so you'll hear about a glass of something over dinner".* It appears knowledge of routines, reasons for drinking and recognition of the negative reasons for alcohol use, supports informed assessment decisions being made. However, no participants identified any formal training where they gained their knowledge;

rather their knowledge appeared to come from their life experiences. Given the context of practice and particularly in terms of establishing a professional foundation for practice, this is a significant finding of this study.

Some participants highlighted negative reasons for use that connected directly with ageing:

> *It's just the grief and loss and the huge change that comes with that time of life, it's when the body is giving up, the brain isn't keeping up with the body or the body isn't keeping up with the brain and there's huge questions around the sense of self and self-worth and contributing and it's really hard* (Nellie).

Donna highlighted the area of 'events' such as marriages and rugby matches as reasons for use, this has been placed in both positive and negative sections (positive due to increased social contact for an OA, negative as a result of increased use). Donna particularly mentioned "*When the nation celebrates*" as a time of increased use and presentations to hospital following injuries.

Overall the participants recognised that understanding patterns of alcohol use was important as part of the assessment process. None of the participants identified formal training as being where this knowledge had been gained. That is despite the fact that having an understanding of the reasons for OAs alcohol use impacts on a RSW's practice by providing a framework of reference (in terms of symptoms) while undertaking assessments, which in turn influences the participants' completion of an accurate assessment.

Gender differences

The majority of participants identified differences in male and female presentations regarding alcohol use and reasons for differences in use between genders.

Most participants believed males presented more frequently regarding alcohol use than females, with two participants believing female presentation was more frequent. Interestingly female drinkers were described in a more negative light by participants. For example Lucy described female users as; *"Sad and lonely wine drinkers".* Lucy and Donna both believed men are more honest regarding their difficulties with alcohol, just; *"Getting on with it"*, whereas women often 'play games'. Donna demonstrated her perception that female drinking was more

significant an issue. She explained that women have a role as; *"Nurturers of children*", and drinking may compromise their ability to safely protect children. Donna felt this perception of women remains with them throughout their lives.

While not directly asked, the perceptions regarding alcohol use and gender held by the participants appeared to be derived from practice and life experiences, since they had not undertaken any formal training on this issue. Having set perceptions regarding gender differences impacts upon practice decisions and assessment outcomes, as questions asked during the assessment may not be neutral or consistent. Formal education and / or robust supervision may help to challenge the impact of perceptions upon practice, achieve consistency of assessment and therefore improve outcomes.

Recommended levels of safe alcohol use

The participants' understanding of the reason OAs are recommended to consume lower levels of alcohol were explored. In a similar way to the sections above the influence of formal training was also considered.

None of the participants displayed any knowledge regarding the reasons for recommending lower levels of alcohol use for OAs. Some believed this subject had no connection to the social work role. For example, Donna felt safe levels of use was not relevant to social work as it was a medical issue. Conversely Donna thought it important to have discussions on how to use alcohol and remain safe. Donna knew body weight was a factor but clarified this as being about putting on weight and the associated heart attack risk.

When asked if she was aware of any advice for OAs regarding levels of consumption Susan explained; "*No, I don't think so it's standard for everyone isn't it?"* Trudi felt similarly, remarking this cohort of people should be considered the same as any other group regarding safe amounts to drink, except that tolerance may increase as people age. These perceptions of OAs being the same as all other cohorts clearly impact upon participants practice decisions, indicating a lack of knowledge and absence of training regarding OAs and alcohol.

Undertaking assessments without basic knowledge impacts upon a RSW's ability to complete accurate assessments and recognise the particular needs of this cohort. It should be noted all participants demonstrated a commitment to ensuring OAs risks and needs were identified, although none had taken steps to acquiring knowledge regarding OAs and alcohol.

Lack of education and knowledge about safe levels of alcohol use for OAs is an important finding from this study - participant education levels regarding this subject were non-existent. This was a surprise given the majority of participants potentially assess OAs and alcohol use in current employment. This lack of education and the participants' limited knowledge arguably impacts on their ability to complete accurate assessments that truly reflect the needs of OAs.

How the impact of alcohol use is considered as part of assessments

This section discusses the participants' views concerning the impact of social influences on OAs alcohol use. Possible risk factors (including injuries) resulting from alcohol use and whether these factors are considered as part of assessment processes is also covered. This data relates primarily to the second aim of the research: explore whether socially constructed perceptions of OAs contribute to participants' ability to assess alcohol use.

Social factors

Half of the participants identified social factors that led to increased risks for OAs using alcohol. These risks included influence from others drinkers, self-neglect resulting from alcohol use and the social impact of alcohol use (isolation), vulnerability and behavioural issues. Tarren commented that, *"Socially if you're at the heavy end of drinking you end up mixing with people who are similar. You isolate yourself if those around you don't want to drink like you do".* Tarren ensured she considered these risks as part of assessment processes, enabling an accurate assessment to be undertaken.

Trudi identified vulnerability within a pattern of one woman going home, drinking, falling and having a; "*Really unhygienic nasty house*". While this pattern of behaviour was frustrating for Trudi, she recognised the importance of being supportive because the woman had capacity to make decisions. This highlighted system colluded risks as different parts of the health system were not working in partnership to effectively address this ongoing issue. Trudi and Tarren also both discussed vulnerability in form of the potential for OAs to be taken advantage of financially.

Lucy demonstrated how social risks are different to medical ones;

> *"If it is having a negative impact on them even if it is social rather than medical then they should be offered the right type of support. Just because you're 75 doesn't mean you should want to have a miserable last five years of your life."*

Social factors also increased risks regarding alcohol use; “Alcohol is a big part of lots of patient’s problematic lives, so lack of eating, lack of taking their drugs properly, lack of supports because they have burnt bridges with family and friends”. Lucy believed the social behaviour of OAs can increase other risk factors and should be considered as part of assessment processes. An accurate understanding of the impact of social factors will impact positively on the participants’ ability to undertake accurate assessments.

Increased risk to an OAs health and wellbeing from social factors was identified as significant for many participants. OAs were also seen vulnerable to being taken advantage of. Participants recognised it was important to support an OAs decision, even if they felt it left the person at further risk. Understanding what social influences impact OA’s alcohol use, being able to recognise these, factor them into assessments and support OAs decisions are all important skills required to improve the effectiveness of assessments.

Risks and Injuries Resulting from Alcohol use

Participants were asked whether alcohol use increased the risk of harm or injuries to OAs, their responses are covered in narrative form below and summarised in Table 4.3.

Table 4.3 Risk factors resulting from use

Participant	Risk Factors for OAs using alcohol
Kelly	Falls, impact on medications
Trudi	Falls, vulnerability
Tarren	Falls, fragility, impact on brain vulnerability
David	Falls, decision making, impact on brain, dementia
Susan	Impact on brain, falls, mobility, head injuries, heart and liver damage
Nellie	Falls, impact on brain, liver damage
Lucy	Medications
Donna	Falls, fragility, suicide, depression

A range of risks and injuries resulting from alcohol use were identified. These included: increased risk of falls, risk of contra-indications from medication and risk of worsening physical and mental health.

The vast majority of participants highlighted an increased risk of falls resulting from alcohol consumption. Trudi commented; "*When you're older and you have a fall you're more likely to do damage".* Surprisingly for social workers based in secondary health settings only two participants identified the impact of alcohol use on medications. These participants suggested that contra-indications regarding the effectiveness of medication or increased risk of an adverse reaction to medications alongside alcohol are not considered a social worker's responsibility. The implication of this is that an important component of an OAs presentation is missed, which in turn reduces the chances of an accurate assessment being undertaken. This lack of knowledge and understanding of the scope of the role again highlights the need for training in this area.

Despite the participants not identifying the higher risk associated with consumption levels, half of the participants' did highlight potential physical or cognitive impacts from alcohol use. Most focused on the additional challenges they experienced when working with someone who has cognition difficulties rather than of alcohol use being the cause of those difficulties. For example, Trudi identified what she saw as a challenge in addressing use; *"The problem of having someone dementing is they can't retain the strategies you're trying to teach".* Trudi also identified risk factors from stopping use; *"If someone does drink heavily we need to know about it in hospital because of the risks of just stopping, might have withdrawal that might contribute to a bit of confusion or delirium".*

Connecting to findings identified in the Impact of Alcohol section above, none of the participants discussed particular physiological changes for OAs as meaning that even lowered amounts of alcohol consumption can increase risk. This lack of knowledge indicates an absence of education and seems to be based upon perceptions that OAs are similar in their risk exposure to other age cohorts. The participants' perceptions of this cohort being the same as other groups clearly influences the accuracy of assessment process and highlights the impact of lack of education and participants' perceptions have on assessments.

Donna was the only participant who discussed increased suicide or mental ill-health impact for the OA when using alcohol. This was surprising given how many participants highlighted loneliness as a reason for changes in alcohol use (Britton & Bell, 2015) and the mental health backgrounds of some participants. The connection between loneliness and an increase in

suicide is demonstrated by Sacco, Unick, Zanjani, and Camlin (2015) whose work has found that OAs alcohol use is associated with an increased risk of suicide.

As noted earlier Donna believed when 'events' such as royal weddings or rugby games take place rates of presentation to hospital for OAs increase due to injuries resulting from intoxication. Kelly also commented that OAs will go to the; "*Cossy Club or RSA to have a drink*" and Tarren stated there is a perception OAs do not drink but; "*God knows why there are lots of them at the RSA's and Bowling Clubs".* These points connect back to the risks identified within the Social Factors section above and provides further evidence of perception playing a strong role in participant practice, as OAs are seen as not being frequent alcohol users, a fact that underpins many of this study's findings.

While participants identified a range of risks and injuries related to alcohol use, they mainly focused on physical risks- such as falls. Participants appeared unaware that even low levels of alcohol use may harm the OA, and within this only two participants mentioned risks regarding safe medication use. The small number of connections made to medication safety may demonstrate that this part of an assessment process is perceived as a 'non-social work responsibility'. Dziegielewski and Jacinto (2016) place medications as a clear social work responsibility within an interdisciplinary team where social workers may be the first to observe side effects of medications due to frequent contact. Other areas identified included an increased risk of injuries for the OA when socialising or attending events. No participants' highlighted risks from physiological changes for the OA, thereby demonstrating a lack of knowledge / education in this area and seeming to indicate a perception that the needs of OAs were similar to other age cohorts.

The social work approach as part of assessment

Evidence describing the social work approach to assessment was presented in chapter two. The evidence highlighted that the assessment process is not only a process of information gathering for the purposes of identifying an intervention, but also about relationship building in a non-judgmental way, to ensure a positive outcome for the interviewee. Social workers need to remain aware of their own values and bias and the impact these may have on the process.

This section explores participants' views on rapport building, judgment, shame and intrusiveness, which were common themes discussed both in the literature and in participant

interviews. This material relates primarily to the second aim of the research, explore whether socially constructed perceptions of OAs contribute to participants' ability to assess alcohol use.

Rapport Building

Relevant literature identifies rapport building as a means of effectively engaging with the OA, increasing the likelihood of a successful assessment outcome. The impact of building successful rapport and developing trust was explored through the participants being asked "How important was building rapport and developing trust in terms of completing successful assessment processes?" All participants saw rapport building as important for the completion of successful assessments. Kelly illustrated this when she said; "*Explaining why we are asking is important and explaining the reasons that we ask these questions instead of just firing questions at people".* David saw building a relationship as the most important aspect of successful interaction, "*With anyone it's all about respect and dignity and self-determination. It's about building a bridge sometimes"*. Tarren felt rapport building was particularly important for OAs, because; *"They are story based and you weave the questions into the story"*. Donna shared similar views; "*It's about building rapport, each individual is different, and you have to perceive how they are perceiving you."*

Rapport building resulted in more meaningful and honest assessments, Nellie explained; "*It's one of the most important things in order to be able to engage honestly with people and be able to support them in a way that's meaningful". S*imilarly, Susan rated the importance of rapport building, *"I can engage and therefore make the conversation more natural and so it will lead to a more honest answer"*. Trudi was clear that rapport building enables the rest of the interview to be completed; *"Having built that rapport you're not going straight in and asking, so do you drink?"* Rapport building enabled relationships to be formed which led to honest interaction, and therefore successful assessment taking place.

Three participants felt developing trust was an important result of rapport building. Donna connected trust and successful assessment of OAs; "*People are going to be more honest with you if they trust you."* Nellie felt similarly that trust comes from engagement and is required for people to be honest regarding the amount they consume and the associated behaviours.

Participants demonstrated good knowledge in these areas and clearly viewed both trust and rapport building as essential to carrying out a successful assessment.

Judgmental practice

The impact on assessment outcomes resulting from judgmental practice was raised by most participants. That impact and participant's awareness of not wanting to be perceived in this manner are discussed in this section.

The participants felt that not imposing their own values on assessments and not being seen as judgmental was important. David, for example, explained; "*I don't have a right to judge it's not my role*". However, David also stated that in one assessment he had to be, "*The adult"* and tell an OA to stop drinking, which appeared to be in contrast to his comments about not being judgmental. So not being seen as judgmental appeared to depend on context and what participants considered needed to be achieved for a successful outcome. This connects to Biestek's (1957, p. v) views regarding casework; 'Relationship is the soul of social casework'. Cheung (2015) however critiques these assertions explaining they are very European focused. A comparison here can be made with bi-cultural practice in Aotearoa, particularly graduates feeling unprepared for bicultural and cross-cultural social work practice (Walker, Walker & Eketone, 2006). While not directly asked, participants did not provide data regarding either Maori alcohol use rates or bi-culturalism. This was surprising for social workers practicing in Aotearoa. While flagging this subject as important for possible future research, this area is out of scope for this project.

Lucy made a connection between practice and judgment in two statements, firstly she commented; *"Our job as social workers isn't to make people more uncomfortable we are not here to judge",* but then remarked that she did not want to be seen as a, "*Funsponge*" when asking OAs about alcohol use. Participants did not want to be judged or perceived in a negative manner. Participates were not directly asked about feeling judged and this subject is slightly out of scope however, Susan explained she did not want to be judged or perceived in a negative manner; *"I don't want to come over as a nosey bossy social worker*". In contrast she also identified beliefs as having significant influence on who she asked about alcohol; "*The appearance, I know that sounds really judgmental".* Feelings of not wanting to be perceived as judging people impacted on participant practice decisions and therefore assessment outcomes. This is clearly in conflict with basic social work practice values and processes such as; non-judgmental practice and unbiased assessment.

Some participants made links between not wanting to impose their own values and how they undertake assessments. Trudi explained; "*Normalising it really so the questions are not judgmental, it's about asking; is this something you do*". Participants were aware of not wanting to be seen as being judgmental but appeared to be focused more on how they were perceived than completing robust assessment processes. The way participants wanted to be perceived clearly impacted on the process they used, meaning the accuracy of assessment was likely to be reduced.

Nellie felt some OAs would be worried about being judged on amounts they drank, making the asking of questions regarding alcohol uncomfortable. When asking OAs about alcohol use Susan at least doubles the amount the OA discloses, believing OAs will minimise use. Taking such approaches will impact on assessment effectiveness and further demonstrates the impact of perceptions within participant practice.

Participants also identified a broader judgment within the health system approving of OAs using alcohol. For example, Lucy felt alcohol use by OAs is seen as a right by many; *"The medical profession would say if you've made it to 70 you are allowed to drink*". Tarren felt the whole health system could be judgmental; *"There's an assumption that they have got to that age and managed to make things work and it's a value judgment".* Nellie saw this similarly and said; *"They have got this far and are essentially looking after themselves. It is their right to make those choices.* Susan had the opposite view; "*Maybe when you're older you're meant to have got it together and not be drinking so much anymore".*

The participants' perceptions of OAs and their alcohol use clearly influenced how they approached the task of assessment. It also reflected the extent to which OAs were perceived to be judged as individuals by the participants and / or by the wider system. No participants commented on attempts to challenge these system wide judgments, possibly reflecting the hierarchal, inter-disciplinary nature of medically led practice in secondary health settings.

Participants themselves did not want to be perceived negatively while undertaking assessments and this influenced their decision making and processes. Overall, perceptions appeared to have a significant impact on the participants' assessment processes, indicating the need for further education and understanding of effective assessment processes.

Shame

Shame was identified by the majority of participants as a reason OAs feel uncomfortable discussing alcohol use. While participants were not directly asked a question about shame, data was gathered from; "What is your experience of OAs and alcohol?" Participants felt shame or embarrassment regarding alcohol use affected an OA's ability to discuss their consumption honestly. David stated; "*Maybe to them it's a thing of shame, there was the whole Judaic Christian ethic, you know don't get drunk and all that"*. Susan felt similarly; *"In their day those things just weren't spoken about*". Nellie highlighted the same connection between use and shame; *"It could be something they are ashamed of*, *there may be shame and guilt around it".* Kelly made a direct connection between OAs, alcohol and shame when she said; "[It] *can be hard to get older people to talk about alcohol use often because of the shame attached to drinking"*.

David connected directly to the theme of shame when he said; *"Maybe in their thinking it's a thing of shame, it's someone being intrusive in their lives and they want to maintain their privacy*". This belief may result in David wanting to respect privacy of OAs and therefore not ask about alcohol use.

Shame has a significant impact on the interaction between OA and assessor, the building of rapport appears to be important in reducing this, as has already been discussed. The perception held by participants that OAs will be ashamed of their use impacts upon their ability to assess OAs and alcohol use if an assumption is made that every OA feels this way and will therefore be reluctant to discuss the issue.

Intrusiveness

The majority of participants felt intrusive asking OAs about their alcohol use, with some participants feeling uncomfortable to the extent they would not ask at all. Tarren explained; "*It's not comfortable because I guess I just don't see it,* demonstrating her reluctance to recognise this issue. This directly impacts on Tarren's practice as she may avoid asking questions due to feeling uncomfortable. Lucy made a clear connection between alcohol use, being intrusive and her perception of OAs; "*That is quite intrusive and also an expectation that they probably don't drink"*.

Nellie demonstrated how aware she felt about being intrusive when she said; "*The approach is generally always the same, but I guess inquisitive questioning without seeming too nosey about*

it". Nellie was aware of practicing in ways that made her appear in a certain manner, clarifying this further by stating; "*It's completely voluntary as to whether they want to talk about it or not".* Participants appeared to see the person's rights to not be exposed to intrusive questions as more important than that of receiving a robust assessment regarding alcohol use.

Similarly, Donna was clear that she felt questioning around alcohol was justified only when impact was evidenced; "*If it's affecting their quality of life, as in if they're coming in injured and yea, if it affects their safety and if it affects others around them* ". Donna further felt hospitals themselves can be very intrusive; *"Just because you're sitting in a hospital bed unwell doesn't mean you have to tell your whole life story to a complete stranger, it's actually quite invasive*".

Susan was also clear about her reasons for not being intrusive; *"[It's a] sense of it not being my business",* feeling there were subjects that are 'off-limits'. This is surprising given the known health impacts of alcohol and this subject clearly being part of a social worker's responsibility. Lucy felt this was rather dependent on the age of the social worker:

> "*Social work students I've had you know in their 20s, they wouldn't, don't have those boundaried issues, sometimes that's a problem with them as students sometimes they don't have that age appreciation and respect, that I would see as disrespect I guess but actually it's more about why can't you ask that question?"*

The concern that they would appear intrusive was important to the participants of this study, clearly impacting on their practice and assessment processes. It seems awareness of feelings such as shame (for both assessor and assessed) and judgment, or being judgmental, also impacts on assessors' decisions as to whether they will ask an OAs about their alcohol use. Rapport and trust building (see page 76) is seen as a way to address some of these difficulties. Retaining professional boundaries however, is more than remaining familiar with a code of ethics. It is also retaining the ability to identify a range of boundary violations, applying critical thinking regarding relationships and being aware of self and others (Davidson, 2005). Supervision would be an ideal environment to address these issues, information regarding whether this takes place was not offered by the participants.

Overall the participants felt the social work approach was an important factor in achieving successful outcomes from assessment processes. Rapport and trust building was required, and

see as important for engagement and honesty. Judgmental practice and avoiding shame and intrusiveness led participants to allow their perceptions of OAs to impact their decision making and therefore assessment effectiveness.

Alcohol as Part of Standard Health Assessments

The participants' views on whether questions regarding alcohol use should be included as part of standard health assessment processes, and reasons for not asking about alcohol were explored, providing an interesting contrast to findings presented elsewhere in this study.

The fourth aim of this study is to establish whether agency assessment tools support participants to ask OAs about alcohol use. To gather the required data to meet this aim a key research question was; 'What assessment tools do participants use, are they supportive and useful?' Within this topic is a section exploring what services needed to be in place, and the key question of: 'What do participants identify as needing to be in place to improve services?' Also discussed in this section is material relating to the first aim, 'whether participants asked OAs about their alcohol use'. One of the main research questions was 'Should OAs be asked about alcohol use? Why?

In contrast to comments discussed earlier in this chapter the majority of participants felt questions about alcohol use should be included as part of standard assessment procedures and would feel comfortable asking them alongside other health related questions. Kelly stated; *"It's no harder than asking whether someone feels suicidal or like self-harming, it's just part of the assessment.*" Similarly, Susan was clear that she was comfortable asking OAs about alcohol use and this should be a standard question stating; "*You've got to ask them about showering and everything, I do feel like a bit of a nosey social worker but don't worry about it."* Susan explained she did not ask every OA she saw and sometimes just did not think about alcohol. In contrast Donna explained having a set question would feel; "T*okenistic and uncomfortable".* For the majority of participants, it appears having a question regarding alcohol on an assessment tool would make it easier to ask.

All participants stated alcohol was not part of their agency's assessment tool; however, two participants felt their agency's tool provided opportunities to ask about alcohol within other sections. For example, David felt alcohol could be assessed elsewhere; *"When we are assessing some one's emotional wellbeing we are looking at mental health, drug and alcohol".*

Lucy felt similarly, "*Usually around mood and general sort of mental health and stresses and how people deal with that*." Lucy saw alcohol as a standard question for the hospital she worked in but her team does not view questions regarding alcohol as a social work responsibility rather this is seen as a medical issue.

The participants provided two further reasons for not asking OAs about their alcohol consumption. These were: only OAs presenting with a history of alcohol use or clear evidence of current use (injuries/ intoxication) should be asked; and the time available to conduct an assessment may not allow for it. Donna for example, felt there was no need to ask OAs until they presented with clear risks, conversely, she also felt all younger people should be asked to ensure alcohol problems were identified at an early stage.

Half of the participants stated time influenced their decision to ask OAs about alcohol. Kelly stated assessments needed to be; "*Quick and snappy*", she usually reduced the number of subjects she covered, including alcohol, only asking if she saw a reason to ask. Susan felt time underpinned the systemic DHB approach; "*The whole hospital is about getting them out quickly"*. Lucy claimed the hospital system was a; "*Bit of a sausage machine"*, asking questions about alcohol may delay processes. Donna felt that asking OAs about alcohol use may invoke memories, slowing the process considerably. Clearly time was a direct impact on decisions regarding OAs and alcohol use.

Overall, the majority of participants believed alcohol should be part of general health assessments. Context of employment was an influence on decision making, with 'systems' identified as preventing a full assessment from taking place. Time was also a factor that impacted upon decision making and assessment processes.

Alcohol often missed in assessment

The participants were asked whether underlying alcohol presentations were missed during assessments. Some felt health professionals only treat OAs' physical presentations, missing the underlying alcohol problem. However, Donna believed it was acceptable practice to not ask about alcohol as details of use would be found in the case notes; she was not able to offer an explanation as to how the details would be in the case notes if no one had asked. Donna appeared comfortable addressing a physical presentation but would not as a rule ask about alcohol use, feeling this was too intrusive. This is a further example of social workers not

believing alcohol was part of their responsibility. Taking this approach impacts on practice decisions and therefore assessment outcomes, alcohol will not be identified as one cause of a presentation if not part of assessments.

As discussed in the 'Impacts of perceptions' section above (see p. 66) perceptions of OAs and their alcohol use impacts on whether they are asked about it. Lucy felt OAs are not perceived as alcohol users, leading to alcohol being missed as an underlying cause of presentation. Lucy also identified the medicalisation of illness as a reason alcohol use is missed, describing how hospital environments look at medical illnesses such as cancer or lung disease rather than issues people can affect themselves.

Overall, the participants identified that alcohol is missed as a cause of presentation, both by medical professionals and social workers, which would contribute to an inadequate and incomplete assessment. Even though the participants did not feel an alcohol assessment or screen was part of their responsibility, they said they would be comfortable addressing alcohol as part of a standardised assessment. Clearly the participants' perceptions of OAs not being alcohol users directly influences their assessment practices, further demonstrating the impact of perceptions on assessments and outcomes.

Participants use and knowledge of assessment tools

The participants were asked whether set assessment tools, used in their place of employment, facilitated them asking OAs about alcohol use. Also explored was whether alcohol should be included on set assessment tools and what training participants received to use such tools. This section still aligns with the fourth aim of; establish whether agency assessment tools support participants to ask OAs about alcohol use. An example of a question used to gather this data was; "How does the assessment tool facilitate questions around alcohol use?"

All eight participants identified that set assessment tools existed within their agencies. Over half of the participants described how they always used their agency tool, with one participant stating she never used the assessment tool. Donna explained there were two main reasons she never used an assessment tool. Firstly, because the tool is restrictive, and she preferred the service user to direct areas of conversation. Secondly, using a tool would entail more writing, therefore increased time, which could be better spent interviewing people. Donna's assessment practices were unstructured and inconsistent with other participants' processes.

Only two participants reported having received training to use their agency assessment tool. Training provided consisted of a basic introduction with an assumption of learning while progressing. No participants were able to name tools designed specifically for assessing OAs and alcohol use.

The use of assessment tools was consistent among the vast majority of participants. This ensures assessments are undertaken in a consistent manner with tools providing structure and guidance. Nonetheless, according to the participants, the tools used did not contain any questions around alcohol use which was surprising given the impact alcohol has on health-related issues. Little training is provided regarding the use of assessment tools, which risks inconsistent practice and the influence of assumptions within assessments.

Practical considerations for assessment

The participants' views on the impact of practical considerations were explored, covering the following areas: working across services and systems, access and transport issues, and group work. The participants also commented on how assessment outcomes could be improved. They also highlighted ways practical considerations influenced both practice and assessment outcomes. Table 4.4 (page 85) summarises their views which are then further explored in the narrative account.

Working across services and systems

Participants identified the impact of services or systems being disconnected and significant challenges regarding whether agencies were able to meet demand. Two participants felt physical and mental health services were disconnected. For example, Susan stated; *"Don't generally get much feedback from the A&D stuff".* Trudi highlighted a disconnect between a medical and addiction team when she spoke about; *"[A] really good example of the inpatient older adult team not knowing what to do about the alcohol component and the AOD team not really knowing either they kind of came together but there still was a gap"*

David highlighted the challenges of referring between systems; *"The difficulty is if you are going to be referred to Community Alcohol and Drug you have to have a co-existing mental illness."* These gaps result in disjointed practice, thereby reducing the referrer's confidence in outcomes.

Table 4.4 Practical considerations

Participant	NGO / DHB services identified	Local services	Access issues identified	Suggested alternative
Kelly	Local DHB team	Not known	No	Consider whether OAs would prefer to receive services from another OA. Build alcohol into assessments
Trudi	Local DHB and 2 NGOs identified	No	Yes, access and transportation	Joint services between Alcohol and Older Adult teams
Tarren	Local DHB and one NGO	No	Yes, access and transport	Wet House provision (see page 87), moderation of consumption
David	Local DHB services and three NGOs	Not known	No	None
Susan	Local DHB services, two NGOs	No	No	Consider employing an OA who is experienced in Alcohol and Other Drug work.
Nellie	Local MHA services and two NGOs	No	Yes, access and transportation	Community based home visiting service that includes counselling
Lucy	Three NGOs	No	No	None
Donna	Local DHB services and one NGO	No	No	Discussed ward based service for assessment of people, including OAs by local Mental Health and Addiction services

Some participants either felt services were not set up for OAs, ready for an increase in demand, or were simply unaware of services being in place. According to Lucy local services would not be ready for increasing demand; *"No, they won't be geared up for the bulge of baby boomers heading their way"*. Kelly simply explained; "*I'm not aware of services set up for elderly"*. A lack of confidence in service provision or lack of awareness of services may result in reduced numbers of OAs being seen by addiction services.

Donna was the only participant to identify a joined up inpatient service. This entails the local Mental Health and Addictions service assessing people on inpatient wards. This was a new initiative that appeared to be working effectively. What was of concern was none of her colleagues were aware of this development.

Overall the identified gaps indicated that the participants were not confident that services are working effectively, which impacted on practice and in particular working in partnership with other teams.

Access and Transport issues

Participants discussed the challenges of ensuring transport arrangements were in place for OAs. An example of a relevant question regarding this was; "What needs to be in place for OAs regarding alcohol use?" Nearly half of the participants identified access and transportation difficulties have a direct impact on success factors for assessments, Trudi stated;

> *"It wasn't a user-friendly service for her, because the expectation was that she would attend appointments, this is an 80 years plus woman on a walking frame who has to catch public transport then they wonder why people don't engage- they say she's just another addict who's not interested"*

Transport options had a significant impact on whether assessments for OAs would be successful. If an OA is unable to attend a location for an assessment the process will not take place.

Group Work

During the interviews, different forms of intervention were considered in terms of their effectiveness for OAs. A question used here was; "What local services are in place to meet the

needs of OAs using alcohol?" More than half of the participants questioned the suitableness of different approaches used for OAs. Trudi stated; *"Group programmes might not necessarily work for one person who is 80 among a group of young blokes and blokesses".* David believed age differences had an impact; "*They might not be OK going to AA meetings. I don't know".* Nellie commented, *"People are really hesitant to join up with groups so while they feel isolated and lonely they also feel uncertain and shy about joining a group".*

Clearly participants felt group interventions may not necessarily be successful for this cohort. This impacts on practice by reducing the likelihood of participants recommending this form of intervention.

How to improve practice and services

This section provided an opportunity for participants to discuss ways services could be improved. Data here came out of the question; "What needs to be in place for OAs regarding alcohol use?" The majority of participants commented on ways to make assessments more effective. For example, Nellie felt a home based service would be most effective, *"Because of the practicalities of transport it makes sense, flexible you know, anything that requires older people to make an appointment at a certain time just makes it that much harder*". Clearly in her view the removal of barriers to access increases the chances of effective outcomes. Nellie identified a range of improvements when she said,

> *"Potentially it would need to most likely be community based and it would need to be a service that done home visiting, it would need to be community workers or social workers or community health workers with more specific training and knowledge around the issues for older people and alcohol".*

Tarren felt a practical approach would be most effective; *"A wet house*, (a wet house is a controlled environment for people to continue drinking while receiving treatment, Radiolive, 2016) *it's trying to manage those behaviours for a lot of people it's managing the grief and loss and I'm sure that the social connection to stop drinking is pretty hard as well"*.

Three participants suggested employment of OAs to assess other OAs regarding their alcohol use. David felt this was important, *"I don't know how an older person would feel going to someone younger".*

Overall participants identified that practical considerations are significant in terms of successful assessment processes. Put very simply if an OA cannot attend a place of assessment- for whatever reason- the assessment cannot take place. Participants provided a range of considerations to how services can better meet the needs of this particular cohort of people.

Conclusion

This section presents seven key findings derived from the data gathered during interviews with the eight-participating registered social workers. These findings fit broadly into the original four aims of this study which in summary were: 1) are OAs asked about alcohol, 2) the impact of perceptions 3) training and education 4) assessment tools. However, a number of additional points were raised that extend these aims and add to the richness of this research.

One: Participants' perceptions of OAs significantly influenced their social work practice.
Perception of OAs was a critical factor in determining the outcome of an assessment. It was a factor in almost all aspects of participant practice. These perceptions included views about appearance, whether OAs as a group use alcohol, expected behaviours of OAs and that OAs should be treated the same as other cohorts regarding their alcohol use. These perceptions resulted in participants making assumptions regarding OAs which in turn affected assessment outcomes. The participants did not feel comfortable asking OAs about alcohol for a range of reasons including that OAs reminded participants of older family members, meaning asking them about alcohol would feel disrespectful.

Two: A lack of education and knowledge impacted on practice decisions and assessment outcomes.
No participants had undertaken formal training regarding OAs and alcohol use. This lack of training meant participants' knowledge of the physical, social and economic impact of alcohol for this cohort was limited. The participants recognised males presented more frequently, and perceived female drinkers negatively. Many participants felt alcohol was not a social work responsibility; rather this remained with medical staff. There was a lack of accurate knowledge in the area of safe drinking levels for OAs. Because of this general lack of education and knowledge perceptions (that were not challenged) will possibly result in assessment outcomes being inaccurate.

Three: While participants identified physical risks of alcohol use, such as falls, there was a significant lack of knowledge regarding the physiological changes OAs experience.

There was a general belief this cohort should be treated in the same way as other groups in terms of their health needs. This lack of knowledge and the impact of perceptions would likely result in reduced accuracy of assessments. In some cases, an absence of questions regarding subjects such as medication and alcohol, as these were seen as outside the social work role, would increase the risk of ongoing harm.

Four: Using a 'social work approach' to assessment was seen as important.

The literature highlights the need for social workers to approach assessment in a non-judgmental manner, to put their own values and biases aside, and to build rapport and trust with the person they're working with. Participants held concerns about being seen in a negative manner or being seen as judgmental. This impacted on the participants' ability to complete robust and informed assessment processes. Some participants claimed OAs may feel judged during assessments and would minimise the amount of alcohol they consumed.

Likely shame about alcohol use was seen as important by participants. They considered that all OAs feel this shame and this generalization would impact on the success of an assessment. The participants were aware of not being intrusive when assessing OAs, but this was to the extent of not asking about alcohol- therefore meaning a robust assessment could not be undertaken. The wider health system was also seen as judgmental, or even supportive of OAs' use of alcohol. Of note was that no participants attempted to challenge system level judgments.

The scope of the social work role was not clear for participants. Awareness of the boundaries of social work practice, coupled with robust supervision may address this gap.

Five: Participants would feel comfortable asking questions about alcohol use if they were included as a standard part of health assessment tools.

In contrast to findings throughout the rest of this chapter, when presented with the idea that alcohol could be included in standard assessment tools, participants said they would feel comfortable asking OAs about their alcohol use. Participants highlighted physical presentation and time constraints as two reasons they do not ask OAs questions regarding alcohol use. They also did not feel addressing alcohol use was a social work responsibility. Little training was identified by participants to ensure consistency in conducting assessment.

Six: No participants were able to name any assessment tools specifically designed to assess OAs' alcohol use.

As mentioned above little training is used to ensure the use of assessment tools is consistent. The majority of participants use their agency's set assessment tool to support decision making despite it not being designed for OAs and alcohol assessment. Of note is that no participants were aware of tools designed specifically for OAs and alcohol.

Seven: Practical considerations were seen as important for ensuring successful assessment outcomes.

Participants identified difficulties in working across services in a collaborative way. They felt that services were not geared up to meet demand. It was agreed that transport options impacted on the outcomes of assessments. Group work was not seen as appropriate for OAs. However, participants did identify a range of ways assessment outcomes could be improved including, for example, using home-based services.

Analysis of Interconnected Themes

Three strong themes that all have an impact on the effectiveness of assessments and wider social work practice reoccur throughout this chapter. They are:

1) Perceptions affect practice. The participants' perceptions of OAs have a direct impact on their decision making and therefore assessment outcomes. In the absence of formal training and / or robust supervision the participants based assessment decisions on their personal perceptions of OAs.
2) There is a complete lack of education and training. This was a significant finding of this study. No participants had received any training regarding OAs and alcohol use, perpetuating individual beliefs regarding the needs and behaviours of OAs and their alcohol use. Lack of training would be highly likely to lead to inconsistencies regarding the way assessments were carried out and the quality of outcomes achieved.
3) Alcohol use is not seen as part of a social work's role. Among the participants the view that alcohol was not part of the social work role appeared many times. This has a direct influence on the identification of alcohol as one cause of a presentation to services, identifying risks to OAs, and assessment outcomes.

Having established seven clear findings related to the four aims of this research, and three interconnected themes that reoccurred throughout the interviews, the next chapter will relate

these back to established literature identifying similarities and differences and gaps in the established evidence.

Chapter five: Discussing the literature verses participant interviews: Similarities and differences

Introduction

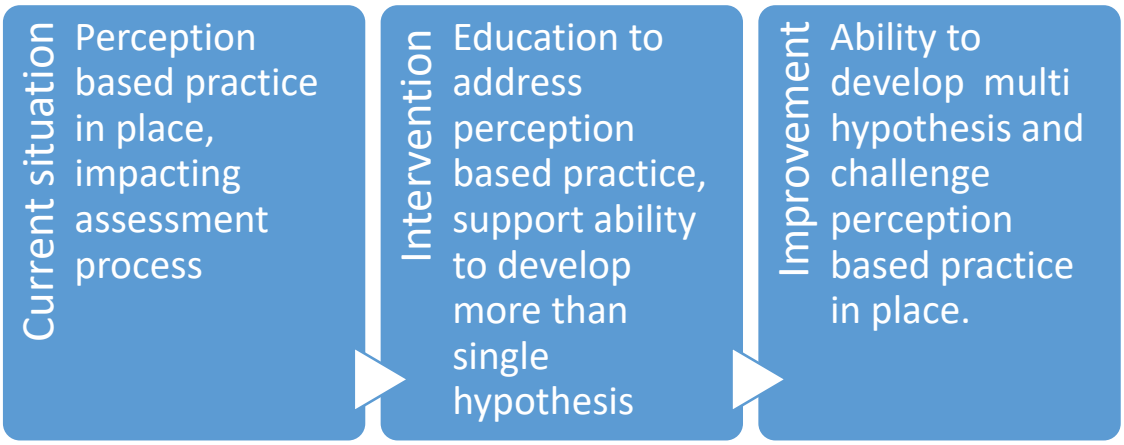
This chapter analyses how the seven findings from the interviews with participants compare to the established literature. Similarities and differences will be drawn out and implications for RSWs practicing in New Zealand are discussed.

The discussion covers the four aims of the study but also includes a number of additional findings that extend these aims. The original aims of the study were to; 1) establish whether participants ask OAs about alcohol use. Participants did not always ask OAs about their alcohol use. The discussion now moves on to focus on why this was the case and what can be done to improve this situation within the remaining aims; 2) explore whether socially constructed perceptions of OAs contribute to participants' ability to assess alcohol use of OAs; 3) establish training levels regarding OAs and alcohol use; and 4) establish whether agency assessment tools support participants to ask OAs about alcohol use. This aim is broadened out to cover areas that are impacted by assessment tools and practical considerations. Following this is an additional section addressing factors within the assessment processes. Finally a conclusion is provided.

Consideration is given throughout this chapter to whether interventions such as education, training and supervision can support a move from 'perception based' to 'evidence informed' practice and how this can improve assessments for OAs and alcohol use. 'Figure 3: Process to evidence informed practice' below illustrates the process of moving towards an evidence informed approach.

Integrated throughout this work is also the three main findings highlighted at the end of the of the last chapter: a) perceptions affect practice, b) lack of education and training and c) alcohol not seen as part of the social work role.

Figure 3: Process to evidence informed practice



Aim two: Perceptions affect practice

The way participants perceived the OAs they assessed was a critical factor in determining the outcome of an assessment. It was a factor in almost all aspects of participant practice.

The four main points emerging from the interviews about the influence of the participants' perceptions were: 1) participants did not consider OAs to be alcohol users; 2) the physical appearance of OAs impacted on participant decision making; 3) participants' views of OAs behaviours influenced their decision making and 4) participants' perceptions originate from personal experiences and media influences. Following a discussion of these points is an analysis of how perceptions affect social work practice and how progress can be made towards an evidenced informed model.

Some participants held perceptions that OAs were not alcohol users, and consequently do not ask them about alcohol consumption. This finding is contrary to established evidence. For example, McEvoy et al. (2013), note a significant percentage of OAs use alcohol with a high number drinking above recommended guidelines. Christie et al. (2013) note OAs who drink in hazardous ways, frequently drink a similar amount to younger drinkers. Similarly, Sorock, Chen, Gonzago and Baker (2006) claim high consumption levels place the OA at risk of a range of negative consequences, and advise health professionals to be frequently screening. However, Schonfield et al. (2010) explain that few OAs are screened, meaning few access interventional services.

The second finding, that OAs' physical appearance impacts on whether participants ask about alcohol use, was surprising. There is little established evidence demonstrating RSWs or other health professionals hold this point of view. One exception to this is Wadd et al. (2011) whose focus group based study found one General Practitioner (GP) who did not see beyond female appearance regarding alcohol risks. The GP saw a 'well presented' older woman and could not perceive her as a regular alcohol user. This example was similar to the participants' views gathered in this study,

Thirdly, some participants demonstrated beliefs regarding OA behaviours such as: OAs were nice people who play with grandchildren, they do not go out clubbing or partying and do not experience hangovers. This finding demonstrates that participants perceived OAs as a homogeneous group. However, OAs are a cohort with more heterogeneity than any other (Kane, Lacey and Green, 2009). Health professionals should consider this individuality, not doing so results in unfounded perceptions influencing decision making and perpetuates ageist beliefs (Kane, Lacey & Green, 2009). In other words, OAs have unique needs and assessments should be tailored to meet those needs (McInnis-Dittrich, 2014).

Finally, participants' beliefs about OAs originated from personal experiences and media influences. Coupled with an absence of education or supervision to support critical reflection, this contributes to initial assessment decisions being underpinned by a 'perception based' approach. There is some evidence that supports this phenomenon. For example, Chonody and Wang (2014), claim student social workers perceive OAs as a depressed or lonely group with poor hygiene. While Kane (2008) argues, ageism is thriving in health settings, leading to therapeutic nihilism (refusing or not recognising people for treatment). This evidence is supported by the findings from the participants' interviews undertaken.

Some participants believed their images of OAs came from positive media messages or spending long periods of time with grandparents. Contact Theory suggests exposure to a group of people will lessen a person's negative beliefs regarding that cohort (Allport, 1954). According to Chonody and Wang (2014) this may not be the case for brief work based contact however. Therefore, social workers without deeper personal exposure to OAs may be influenced by socially constructed perceptions.

There are a number of authors whose work highlights the risk of perception based practice dominating within social work. Firstly, Raskin, and Widrick (2010) claim the concept of socially

constructed messages are explained by the golden section hypothesis. This approach states that people perceive others in a positive manner in around 60% of instances, whereas OAs are only perceived in a positive manner around 40% of the time. This directly supports the findings of this study because participants' socially constructed beliefs resulted in perception driven practice. For example, one participant claimed the extent of an OA male alcohol use was apparent by looking at his nose. This socially constructed perception of an OA male results from the participant having only a single hypothesis of practice which they chose not to prove or disprove by triangulation to other evidence, resulting in perception based practice.

Scott (1989) claims following initial assessments social workers seek confirming rather than disconfirming data and their reasoning is frequently not supported by hypothesis development or exploration. Similarly, Kelly and Miller (1996) found a tendency for social workers to verify their initial assessment, with little re-evaluation of initial data resulting in social work options being extremely limited, and social workers frequently self-justifying to support their initial hypothesis. This provides a theoretical framework for why socially constructed perceptions result in perception based practice, until challenged by robust supervision or training that enables RSWs to address single hypothesis generation and assessment bias.

In summary, participants reported making decisions that appeared to be influenced by their own socially constructed perceptions regarding OAs alcohol use. These perceptions contributed to them refraining from asking OAs about alcohol.

Discussion of perceptions findings

This discussion raises questions regarding why the participants did not perceive OAs as alcohol users, and the origins and influence of participants' perception based practice. Participants in this study were strongly influenced by their perceptions in the course of their social work practice. This is despite the literature highlighting the need for social workers to be aware of the potential for bias in their work. A lack of professional, robust practice, based on clear reasoning and hypothesis building will have an impact on the way that services are designed and funded. Better education and supervision are tools to counter the reality that social work assessment is a complex art that can be subjective without proper process. Ney, Stolz, and Maloney (2013) comment that social workers should remain aware of their own values and bias and the influence this may have on process. Murdoch (2014), and Wadd, and Galvani (2014) claim

health professionals' misconceptions result in OAs not being asked about alcohol use. Both of these points in the literature support this study's findings.

Perception based practice can also have implications for service funding, design, eligibility and access. Kane, Lacey, and Green (2009) state that OAs are, at times, portrayed by policy makers as having low levels of function which in turn enables access to a larger amount of limited resources. While this may be positive as it enables access to resources, it still portrays OAs in a negative manner. In direct contrast to the views demonstrated by the participants in this study, The New Zealand Health Survey (Ministry of Health, 2014/2015) demonstrates clear evidence of OAs being alcohol users, which is significantly underestimated among practitioners in the sector. This supports Kuerbis, Sacco, Blazer, and Moore's (2014) claim that rates of OA alcohol use are significantly underestimated. Planning for services on a framework of perception based practice therefore has wide reaching implications for the level of service provision and funding. Social workers acknowledging the evidence that OAs do regularly use alcohol, could lead to more evidence informed assessments, that more effectively meet OAs needs and record accurate data.

This study has demonstrated participants did not ask all OAs about alcohol use. What remains unknown is why this is the case, some evidence offers explanations for this. For example, Wadd, and Galvani (2014) argue that health professionals do not feel comfortable asking, or do not feel alcohol is part of their role. Murdoch (2014) also claims professionals feel embarrassed to ask OAs about alcohol. This is described in this thesis' findings as uncomfortableness. Overall this raises questions as to whether other RSWs' decision making is influenced by appearance and whether these issues are discussed, explored and challenged within supervision or training.

This study's findings regarding how participants' thought OAs' behaved were surprising and not supported by established evidence. One explanation for this may be that perception based practice is not being critically discussed and reconsidered by exposure to training or supervision. O'Donoghue and Tsui (2012) question whether the development of a formalised checklist for supervision would ensure safety, risk, rights and opportunity are all addressed. This study suggests 'perceptions' could be included on such a list.

It should be noted that each participants' responses at interview were influenced by their own personal approach to how they gathered and analysed information. Milner, Myers, and O'Byrne

(2015) highlight a risk called ‘hypothesis conformation bias’ in social work assessment, which is characterised by social workers being heavily influenced by their initial information gathering, as demonstrated by this study’s participants. Sheppard, Newstead, DiCaccavo, and Ryan (2001) found that the lack of ability to undertake data analysis at a level of rigor required of social work practice, combined with the risk of confirmation bias from workers generating only one hypothesis, results in a need to build an understanding of ‘knowledge through process’, (referring to the reasoning process social workers undertake when reviewing information for decision making) into education curriculums.

Sheppard (1995a) also suggests that ‘knowledge through process’ involves generating a hypothesis and testing it through falsification - meaning in simpler terms, generating different explanations and testing them. Sheppard (1995b) offers two options for how this process could work: ‘progressive hypothesis development’ (the worker seeks falsification data until the hypothesis fits the situation); and ‘comparative hypothesis assessment’ (worker compares different hypothesis to test which the data better fits). In this way, Sheppard, (1995b) compares social work practice to social research. Although not directly asked if they employed a particular framework to their practice, there was little evidence of these kinds of processes being undertaken by this study’s participants

Sheppard and Ryan (2003) argue that social workers use ‘rules’ when developing a hypothesis. These include substantive and general rules used to understand or make sense of a situation. An example from this study could be how participants did not use any clear rules to establish their position that OAs are not alcohol users. Application rules refer to how rules are applied, this could refer to not asking OAs about alcohol use. Practice rules stipulate the response a worker feels is required to a situation, in this study some participants were uncertain where to refer an OA who did disclose alcohol use. Building a set of rules by which to conduct an assessment is essentially a theoretical framework for decision making. As stated there was no evidence to suggest participants were using such a framework to support decision making.

In summary, robust education and supervision regarding the way RSWs assess OAs and alcohol use could include the introduction of a balancing checklist where perceptions could be challenged and information gathered continually reconsidered. The next section considers the reasons participants might not ask OAs about alcohol.

Why participants might not ask OAs about alcohol use

This section questions whether the perception based approaches described above contributed to participants' abilities to ask OAs about alcohol use. The participants did emphasise the importance of forming relationships with OAs before asking them alcohol related questions. The majority also explained how developing good rapport is vital when working with OAs, requiring time and an unhurried approach (Wadd et al., 2011).

However, participants also identified lack of time as a reason for not asking OAs about alcohol. They felt this may recall memories there is not time to hear, demonstrating a socially constructed perception of OAs talking too much when answering questions or perhaps recognition that some OAs may take longer to process information when responding to questions. An alternative explanation is that participants felt they simply did not have enough time for interviews. This has implications for both participants and District Health Boards (DHBs) as employers. DHBs need to consider whether social workers are able to assess effectively without time for developing rapport, which may result in risks not being identified. With sufficient time, all OAs could be asked about alcohol use, meeting best practice advice as covered elsewhere in this study. Further research is required to establish whether RSWs do not in fact have enough time to properly conduct assessments, whether this was just a perception and the extent of this belief among other RSWs.

Reluctance to ask OAs about alcohol use is well-documented. In a New Zealand context Burns (2015) identifies the following myths: OAs are too old to change, it is wrong to interfere in a personal issue and OAs are entitled to consume and shouldn't be robbed of their last pleasure. These reasons are derived from socially constructed perceptions and were demonstrated by the participants of this study based on their own experiences, knowledge, skills and values. The inability to see other realities beyond socially constructed views is termed by Allen, Cherry and Palmore (2009, p. 132) as 'cognitive laziness'. The participants in this thesis are products of a system that provides no training. This system has created cognitive laziness in terms of participants not having the ability to develop further hypothesis, resulting in a limited range of options with which to make decisions. Training curriculums aimed at specific age cohorts may help to lessen the influence of perceptions on practice and would support a move towards a more evidence informed approach (Kane, 2008).

To mitigate against the tendency for perceptions to influence social work practice a number of tools could be used. For example, checklists could be built into assessment processes to guard against social workers being heavily influenced by initial data gathering and resulting premature hypothesis development. Checklists can be systematically used, reviewed and refined (Milner, Myers and O'Byrne, 2015). A national survey or practice audit would identify the transferability of such checklists among New Zealand based RSWs.

This thesis has established that socially constructed perceptions impacted upon the participants' abilities to ask OAs about alcohol use. These perceptions take the form of, for example: OAs talking too much and participants being reluctant to ask OAs about alcohol use as this cohort experiences shame and stigma. They impact on decision making when not challenged and practitioners are reliant on their initial assessments, not challenging potential hypothesis bias. The following section addresses how education can address these gaps in knowledge.

Aim Three: Education and knowledge

None of the participants in this study had received specific training or education regarding OAs and alcohol. Nor it appeared had they received, or put in to practice, training in frameworks or tools that could assist them to conduct more robust assessments.

Wadd et al. (2011) recommends training regarding OAs and alcohol is critical to challenge ageist attitudes and myths, increase competency, and ensure social workers understand latest research in this area. Similar recommendations are made by Galvani (2015) when identifying the educational needs of social workers in relation to substance use work being a minimum standard of content and skills relating to substance use within social work qualifying education and training regarding substance use is a requirement of qualifying course content.

If social workers are not clear how they should be working with people with alcohol difficulties, education is a fundamental requirement if this is to change (Galvani, 2015). Low levels of education and knowledge were also demonstrated in a study by Waldon and McGrath (2012) who explored the knowledge base of allied health staff and nurses in Eire. They found 92% had not undertaken any training regarding OAs and alcohol use.

One risk arising from a lack of training in this area is that it may lead to conflicts with relevant Code of Ethics. For example, section 4.3 of the Aotearoa New Zealand Association for Social Workers Code of Ethics (2007, p.12) states; 'Social workers should take reasonable steps to

ensure that the workplace is culturally appropriate for the clients of the organisation'. This would be hard to achieve if social workers are unaware of the particular needs of OAs. Similarly, section 3.5 of the Social Workers Registration Board Code of Conduct (2016, p. 9) states social workers are expected to; 'Maintain professional objectivity'; again, hard to achieve with a complete absence of training in this area. Both the social worker and employer have responsibilities for education in this area. This is discussed further within the conclusion and recommendations.

Participants believed there were differences in behaviour between genders. The majority of participants identified that males present more frequently than females. However, males were perceived as honest and 'straight up' regarding drinking, whereas, women were perceived as 'game-players' and difficult to work with. There is little established evidence to support women being harder to work with than men. The only relevant study that highlighted a significant gender difference and went some way to supporting participants' views was Gell, Meier, and Goyder (2014) who found women less likely to disclose drinking difficulties.

Some evidence suggests that the impact of alcohol use is different between genders. Yoneyama and Lima (2015) claim women experience alcohol related cardiomyopathy at lower levels of alcohol consumption than men and any benefits from consumption are lesser for females. No participants demonstrated knowledge in this area, possibly resulting in risks being unidentified. An absence of education is likely to explain participants' lack of awareness of the established evidence.

Some participants held perceptions that OAs should be treated the same as other age cohorts regarding their alcohol use. This demonstrates a lack of awareness of the physiological changes associated with ageing. This perception is not supported in the established literature which demonstrates that OAs have particular reasons to be treated differently to other cohorts regarding alcohol (Nelson, 2012). Kuerbis, et al. (2015); Nelson (2012), and Sharp and Valch-Haase (2011) all identify a significant range of physiological health changes for OAs which changes their response to alcohol. Wadd et al. (2011) also explain how OAs have different risks and stresses regarding alcohol. They face unique barriers to treatment, which are poorly understood among health professionals. No participants knew of or understood the physiological changes and few actively screened every OA. A lack of education and an inability

to consider other hypotheses have contributed to assessments being influenced by a perception based model.

Finally, participants demonstrated no knowledge regarding safe drinking levels for OAs. Confusion here is understandable, as there is no universally agreed definition of safe drinking. In New Zealand, there is an absence of clear health promotion literature regarding alcohol for OAs (Hodges and Maskill, 2014). With an absence of clear advice in New Zealand OAs are drinking in more hazardous ways than ever (Towers et al., 2011), and face greater risks from lower levels of consumption than their younger counterparts (Sorock, Chen, Gonzalgo, & Baker, 2006). New Zealand's Health Promotion Agency (HPA) (2016) website offers the same safe drinking limit advice for OAs as for working age adults. This is concerning as many OA males are unaware of any recommendations regarding safe drinking levels (Gilson, Bryant & Judd, 2014). Other jurisdictions have developed advice tailored for OAs. In the United States of America, The National Institute for Alcohol Abuse and Alcoholism (Savage & Finnell, 2015), recommends no more than three standard drinks a day, and no more than seven a week for OAs who do not take any medications.

Similar to other findings in this study some participants felt safe drinking levels was not an area of social work responsibility, believing this to be a medical issue. However, DrugScope (2014) claim a lack of clear safe drinking advice is a barrier to identification of harm and treatment, indicating health professionals, therefore by extension social workers, require knowledge in this area.

Education and training: Discussion on findings

Consideration needs to be given to the reasons participants had gaps in their knowledge and the likely extent of these gaps among RSWs generally. In particular, the absence of training specifically about alcohol use by OAs among the participants, highlights a gap regarding current opportunities provided by Health Workforce New Zealand[2] and the availability of post graduate training for RSWs working with OAs. Te Pou's[3] (2016) website lists a range of Addiction training but makes no mention of OAs and alcohol as a training option. Employers also have a

[2] Health Workforce New Zealand leads and supports the training and development of the health and disability workforce. http://healthworkforce.health.govt.nz/

[3] Te Pou o te Whakaaro Nui is a national centre of evidence based workforce development for the mental health, addiction and disability sectors in New Zealand. http://www.tepou.co.nz/

responsibility to ensure RSWs are provided with adequate levels of training to undertake required tasks, though this is hard to achieve in the absence of suitable educational options.

The lack of knowledge regarding gender differences, physiological changes and safe drinking levels for OAs among participants is not surprising, as they are products of a system that does not require social workers to complete training in this area. There is a responsibility upon education institutions offering social work qualifications to make their courses fit for purpose. If social work training is inadequate, post graduate opportunities to specialise are not offered and employers do not continue to up-skill and supervise employees -what may result is practice based on socially constructed perceptions and continual development of a single hypothesis not challenged by alternative information or data. A move to more evidence informed practice requires clear knowledge and information to be provided to participants and others working with OAs. The next section explores how these concerns impact on assessment processes.

Training levels regarding OAs and alcohol use

None of the participants had undertaken training regarding OAs and alcohol use. Further research could look at whether the findings in this study could be replicated in other parts of New Zealand; adding weight to what has been discovered here. The established evidence demonstrates a lack of education regarding this subject is not just a New Zealand issue but an international one. This study indicates the need for staged educational programs covering: graduate social work training, post graduate training and specialist training. This study also highlights the need for training beyond what is currently advocated for in the literature, including: developing questions as part of standard health assessments, the ability to question and challenge assessment bias, recognise single hypothesis development and address socially constructed perceptions. These different stages are summarised in Table 5.1 on page 97 and discussed below.

Graduate training

Including within qualifying training courses, the requirement to develop the ability to question and challenge assessment bias, recognise single hypothesis development and address socially constructed perceptions, will contribute to graduating social workers meeting what Wadd and Galvani (2014) regard as two of the three requirements to work effectively with OAs regarding alcohol. The first being RSWs engaging in a way that does not make the OA feel ashamed for their use. Second is the ability to put aside ageist attitudes and myths, for example acknowledging the realities that OAs are alcohol users.

Table 5.1 Training stages regarding OAs and alcohol

Stages required	Training to be undertaken
Qualifying Training	Develop an: • understanding of the realities of OAs as alcohol users. Understanding of the behaviours of OAs as individuals. Ability to engage with OAs in a way that reduces feelings of shame and guilt regarding alcohol use • awareness of Brief Interventions / **FRAMES**: **F**eedback -of personal risks, **R**esponsibility individual choice, **A**dvice- deliver clear advice to person. **M**enu- provide a range of options, **E**mpathy- an empathic approach will usually deliver better results
Post Graduate Training	• Know what life changes and physical signs / symptoms are associated with problematic alcohol use • Have a basic understanding of medical conditions and medications leading to adverse reactions with alcohol • Be confident to address alcohol and medications as part of RSW assessment responsibilities • Be able to screen and discuss alcohol use with OAs tactfully and sensitively • Understanding the impact of physiological changes for the OA
Specialist Training	• Awareness of risks associated with lower levels of alcohol use in OAs • Understand the distinction between early and late onset drinking • Ensure premises for assessment are accessible, safe and culturally appropriate • Deliver assessments that account for differences unique to OAs • Offer consultation for professionals on OA alcohol use • Develop a good understanding of relevant research and gaps in evidence

Areas identified but not well covered in literature	• Asking alcohol related questions as part of standard health assessments • Having knowledge of assessment tools designed for the OA • Understanding the reasons behind RSWs' perceptions needs to be explored by those social workers during their qualifying training. This forms their ability to question socially constructed perceptions, challenge the development of single hypotheses and recognise assessment bias

Addressing these issues at a graduating level is necessary to equip the entry level social worker with a range of evidence informed knowledge and skills and it would go some way to reaching Galvani's (2015) recommendations (discussed above) of alcohol training needing to be covered to meet minimum standards of content within graduate training.

Post graduate training

Post graduate training is an important avenue through which RSWs can expand their knowledge of interest areas, test or confirm experiences they may have had in the course of their practice or update their knowledge. One area of concern from this study was participants' view that combined medication and alcohol use are not part of their responsibilities, resulting in possible risks of harm being missed. Addressing this would meet Galvani's (2015) recommendation of alcohol being accepted as part of social work duties and responsibilities. Furthermore, RSWs need to develop an understanding of basic medical conditions and medications impacted by alcohol use. For this to take place RSWs require an understanding of life changes and symptoms relevant to the ageing process (physiological changes for example). Continuing to develop an approach to their practice that engages with OAs, to reduce stigma and shame, will support successful engagement and assessment outcomes.

Specialist training

Specialist training is required for a group termed 'mainstream alcohol practitioners' (workers in generalised alcohol practice with skills to work with OAs) (Wadd et al. 2011). This is a group who need to develop specialist skills tailored to meeting the needs of OAs. Further research could confirm whether the findings from this study are New Zealand wide and whether there is an appetite for more specialist training to meet this gap.

Training areas not well covered in literature

Several potential areas for specialist training, not well covered in the established literature have been identified through this research. Training in these areas is vital if OAs needs are to be effectively assessed and good outcomes achieved. Most importantly, examining the reasons individuals' have developed their perceptions in more depth, could help to develop the social worker's ability to: question their socially constructed perceptions and challenge single hypothesis development and assessment bias.

In summary, the evidence highlights the importance of social workers having a good understanding of the research base regarding OAs and alcohol; and developing robust knowledge of and awareness of gaps in the evidence (Galvani, 2015; Wadd et al., 2011). This thesis has demonstrated the evidence base among participants regarding OAs and alcohol use is low, resulting from being products of a system that lacks education. For example, the participants displayed little awareness of the risks for OAs from lower levels of alcohol use compared to younger cohorts. This is understandable in the context of no education being available regarding the age related physiological changes that OAs experience.

Social workers are part of a diverse allied health workforce with a wide range of training needs. It is possible that training regarding OAs and alcohol may not be seen as important for some professionals across health settings. This position has been demonstrated to be a risk to the quality of assessment and outcomes for OAs throughout this study. Further work, possibly by Health Workforce New Zealand is required to establish evidence for this hypothesis.

Additionally, the move away from perception based towards evidence informed practice includes: a) developing a detailed understanding of the impact of physiological changes experienced by OAs; and b) the ability to develop alcohol questions within standard health assessments, a 'perception to standard question' approach. Alongside these skills, knowledge of assessment tools designed for the OA is required, these are considered further in the next section.

Aim Four: Agency assessment tools ability to support participants to ask OAs about alcohol use

In addition to discussing the use of assessment tools this section focuses on the following four areas. Firstly, the quality of assessment tools. Secondly, alcohol as a standard health question.

The third area concerns the practical considerations of doing an assessment while the fourth presents social work as part of wider health systems.

Firstly, the quality of agency assessment tools is considered. All bar one of this study's participants used assessment tools, however none of these tools contained questions regarding alcohol.

Gell, Meier and Goyder (2014) claim the reason data collected about OAs and their alcohol use is incorrect is a lack of awareness (of risks) and incorrect beliefs among health professionals. They also claim that less than ideal assessment tools are used in health settings, and that assessment tools need to be specific to the cohort being assessed. What needs consideration here is why OAs are not seen as a group requiring specific assessment for alcohol use and therefore why participants were not using such a tool consistently. One explanation is that perceptions of OAs as non-users of alcohol is system wide. Not including alcohol related questions in basic screening tools is not unique to New Zealand or to social work. Maclean, Gill, O'May and Breckenridge (2015) explored the use of standard assessment tools for alcohol among occupational therapists in the United Kingdom. Of 122 participants, none used standard tools. Using a tool with set questions regarding alcohol would support participants in asking all OAs about usage, as the asking of such questions becomes part of standard practice. Moving in a direction of standard health questions reduces the risk of relying on a perception informed approach to practice and aligns with an evidence informed approach, this study has termed this 'perception to standard question'.

None of the participants had an awareness of assessment tools designed specifically for OAs. Tadros et al. (2015) explain that internationally traditional assessment tools are not formatted to consider issues such as medical conditions and medication usage, and are therefore not suitable for OAs. However, the Alcohol-Related Problems Survey (ARPS) is a modern tool that is formatted for specifically for OAs. It is used in Australia and is being validated for New Zealand use (DrugScope, 2014).

In New Zealand, current assessment tools specifically designed for assessing OAs and including alcohol have not been validated for the local population (Paech & Weston, 2009). From searches undertaken for this study no official advice was found regarding use of assessment tools designed specifically for OAs and alcohol use. With this as the current context, limited awareness of suitable assessment tools and therefore inconsistent assessment

practices is understandable. Hodges and Maskill (2014) advocate research to be undertaken in New Zealand to understand which alcohol assessment tools would be most suitable for a local population, the Ministry of Health should be undertaking this work and providing clear direction on which assessment tools be used.

Secondly, including alcohol related questions on standard assessment tools, which are already in use in health settings, may increase the numbers of OAs screened, and support a move towards evidence informed practice. The majority of participants felt alcohol should be considered as part of standard questions alongside other health related matters. Evidence indicates this is a positive approach to reduce OAs alcohol consumption (Livingstone and Galvani, 2012). This raises questions as to why most participants did not ask all OAs about alcohol. One explanation may be that OAs have to overcome socially constructed barriers, such as not being seen as users, before being asked about alcohol. Another explanation is that medical attention frequently focuses on physical conditions, rather than alcohol as an underlying cause (Wadd et al., 2011). Building alcohol into standard assessments may refocus professional attention and go some way towards supporting a move from perception based to evidence informed practice. If questioning about alcohol use was a more normal part of standard assessment practice for social workers, it could also establish social work as a leading profession in terms of addressing OAs and alcohol.

Evidence of the need for education for social workers about the importance of considering alcohol use as being within their scope of practice is provided by Dance and Allnock (2013) who found that, just because an alcohol question appears on a form does not mean social workers felt it gave them the right to ask about it. That point was evidenced in this study which would suggest this has not been addressed in New Zealand and current practice is rooted in system wide perceptions of OAs as non-users of alcohol.

Thirdly, practical issues are important to address as a means of improving assessments. Access and transport were highlighted by participants as barriers for OAs wanting to use services. They identified home based approaches as being of most benefit to address this. Established evidence supports this approach. For example, Dance and Allnock (2013) identify the challenges of OAs attending intimidating local community alcohol services. DrugScope (2014) also note that addiction clinics can be very unwelcoming for the OA, highlight transport as a challenge, and resource constraints as additional considerations.

Group work was not considered suitable for OAs by participants in this study. They perceived this as an Alcoholics Anonymous type approach for younger people, though accessing services provided and attended by people of the same age was seen as important. However, Wadd et al. (2011) highlight that OAs attending some form of group was a motivating factor by providing mutual support. They did concur with participants' views that many OAs feel more comfortable in attending a same age group. To implement this knowledge participants could take the lead in improving clinic settings and ensuring OAs receive effective services. Further research could be conducted to discover whether RSWs across New Zealand are already undertaking these roles and whether it is effective.

Fourthly, participants reported that health professionals in the wider system also have perceptions regarding OAs and alcohol use. An example included medical professionals assuming once an OA had 'made it to seventy they were allowed to drink'. Within a medical hierarchy these perceptions impacted upon participants' abilities to complete effective assessments. For example, one participant felt she was questioned regarding her views of OAs and alcohol, as she was 'only a social worker'. Although outside of the scope of this project this challenge to professional credibility adds further understanding to the reasons participants did not consider alcohol part of their responsibility. Further research is required to establish whether this is a common impediment to good practice among New Zealand based RSWs. Implementing alcohol as a standard health question and / or including it in assessment tools, would enable participants to practice from an evidence informed approach and again, establish social work as a profession taking the lead in assessing OA and alcohol use.

It appears perceptions demonstrated by this study's participants reflect those held by some professionals in the wider health system. Maclean, Gill, O'May and Breckenridge (2015) claim occupational therapists frequently miss alcohol due to ageist beliefs and a lack of knowledge. Crome, Wu, Rao, and Crome (2015) argue geriatricians are less likely to screen for alcohol compared to other professionals.

Progressing to an evidence informed approach requires social workers to be pro-active. Livingston, and Galvani (2012) claim social workers' skill base means they are ideally suited to work with OAs and alcohol. Galvani (2015) explains social work supervisors / managers need to support staff addressing substance use. This includes creating an environment for social workers to be confident in challenging wider systems, developing collaborative practice across

mixed disciplinary groups and building and fostering understanding regarding other professionals' roles. No participants demonstrated an ability or desire to actively challenge wider system perceptions, possibly due to sharing similar perception based approaches. Further research is required to establish if other RSWs working with OAs are confident in challenging wider systems.

This study has demonstrated that inconsistent and inadequate assessment tools can result in inconsistent assessment outcomes, meaning professional competency can be questioned. One option for improvement is for social work leaders to ensure alcohol is considered as part of standard health assessments. As major funders of health services the Ministry of Health should be providing leadership and direction on how the health and social needs of OAs should be met by working with the sector to ensure alcohol is part of standard health assessments, therefore working towards assessment outcomes being consistent and robust.

Currently, workers based in District Health Board teams are rarely able to undertake home visits due to lack of time and high caseloads, resulting in OAs attending potentially unwelcoming clinics. This could be addressed by having RSWs working with consumers to consider how clinics can be more welcoming for the OA. Social work leaders should be supporting an environment where social workers can take the lead in establishing best practice and challenging wider system perceptions.

Factors within the assessment process

This section discusses the factors within the participant interviews related specifically to the assessment process. The first finding in this area was the lack of participants' knowledge of the reasons for and patterns of OA alcohol use. The next finding was that the participants' were uncomfortable asking OAs about alcohol use. The third concerned risk factors highlighted from assessment and the fourth was participants' views on alcohol and medications as part of social work responsibilities. The last section presents a discussion about the implications of these findings.

Participants demonstrated good knowledge regarding the reasons for OA alcohol use. Loneliness appeared frequently in responses along with: self-medicating, drinking as a habit, lifetime use, grief and marriage break up. The majority of participants also highlighted positive reasons for using alcohol. They included: socialising, enjoyment and liking the taste. The

literature supports this mixed view of reasons for use. For example, Ward, Barnes, and Gahagan (2011) found a mixture of positive reasons for why OAs use alcohol. Whereas Wadd and Galvani (2014) claim the only reason for OA alcohol use is managing stress and pain. In New Zealand, Hodges, and Maskill (2014) note that very little is known about OA alcohol use, whereas Burns (2015) argues a common myth is that OAs are happy drinking and should not be robbed of their last pleasure in life.

The majority of participants also identified some patterns of OA alcohol use, highlighting the discussion of routines as an effective way of identifying drinking within daily activities. Grey (2013) links alcohol habits and rituals to the OA's effort to remain in control of parts of their lives. Patterns of alcohol use among OAs are well established in the literature as three main types: early on-set drinkers (drinking commences at an early age), late on-set drinkers (drinking commences later, often resulting from a negative event) and intermittent drinkers (drinking commences for periods at a time) (Crome, Dar, Janikiewicz, Rao, & Tarbuck 2011; Wadd et al., 2011). While not directly asked, no participants identified these sub-groups of OA drinkers. A low level of knowledge in this area is not unique to New Zealand, nor to social work. In their study of Irish health care workers Waldron and McGrath (2012) recorded the lowest number of correct answers from identifying these sub-groups, concluding this resulted from a lack of both initial and ongoing education.

The finding that some participants were uncomfortable asking OAs about their alcohol use was supported in the literature with Wadd and Galvani (2014) noting there is a reluctance to ask OAs about alcohol due to embarrassment. Murdoch (2014) also identifies discomfort and a misconception that use is rare among OAs. Whereas, Jackson, Crome, Rao and Crome (2015) identify a lack of awareness and training resulting in stereotyping of the OA as non-drinkers.

The third area of knowledge within the assessment process was identifying the range of risks from alcohol use, such as falls, social vulnerability, cognition and physical risks. Dance and Allnock (2013) and Waldron and McGrath (2012), highlight falls as a major risk related to alcohol use. In the New Zealand context, Burns (2015) identifies risks around falls, burns and bruises. Alcohol Withdrawal Syndrome (AWS) was highlighted by participants. This is noted by Taheri et al. (2014) as a risk for OAs resulting from a longer abuse period, putting the OA at risk of a range of neurological and medical conditions. Surprisingly only two participants mentioned

risks regarding medications and alcohol. Overall the participants' knowledge in the area of physical risks was good.

The participants also identified social vulnerability concerns. In the literature, vulnerability and withdrawal from social circles is identified as a risk by Burns (2015). Dance and Allnock (2013) see vulnerability as a systems issue claiming OAs risk being admitted to Aged Care facilities rather than directed to Specialist Alcohol Services. Participants did not make this connection and need to be aware of this risk given the numbers of OAs who enter Aged Care from secondary health services.

The fourth finding, the belief that alcohol use, and identifying the impact of alcohol on medication use, was not a social work responsibility is of particular interest and surprising given the health and societal impact of alcohol. Questions arise as to the reasons for this viewpoint. Working in a hierarchical secondary care environment, where participants are frequently told these issues are not their concern, may contribute to participants' disconnection from this important issue.

According to Wadd and Galavani (2014) and Dance and Allnock (2013) most UK based social work training regarding alcohol is aimed at students working with children. Few social work training providers expect students who will work with adults to undergo alcohol training, setting a tone for little connection being made between OAs and alcohol use. Galvani (2015) claims working with people who use alcohol is a fundamental part of all social work as any OA caseload will contain at least two or three people whose lives are directly impacted by substance use. Daly and Feit (2013) argue effective social workers need to understand and be aware of the medical and health impact of alcohol.

Murdoch (2014) explains that medication use combined with alcohol is a significant risk for OAs, as this can present a range of possible reactions to and effects from alcohol. Crome and Crome (2005) note that OAs receive more prescriptions than any other age group and are often dispensed multiple medications. Moore, Whiteman and Ward (2007) add that many medicines interact with alcohol. Alcohol may possibly increase effects (sedative effect of a hypnotic), exacerbate a side effect (drowsiness associated with anti-histamine use), or result in a new syndrome (the unpleasant effects of combining alcohol and some antibiotics). As the severity of these interactions differs, some medications require total abstinence from alcohol, others require reduced alcohol use.

Discussion of findings regarding the assessment process

The participants displayed some knowledge regarding patterns of, and reasons for, alcohol use. What needs further exploration is the reasons why this knowledge was not always translated into practice. This may relate back to Milner, Myers and O'Byrne's (2015) concepts of assessment outcomes being limited by hypothesis bias, when participants gather data to confirm a single explanation for the assessment outcome. The same authors argue initial intuition may be accurate but requires retesting. Even when only one explanation exists, disproof is an important consideration, in other words retesting a hypothesis is important to ensure its accuracy. In this way information collected may result in the identification of clear themes but any information that does not easily fit will not be discarded. Then all data can be checked for authenticity, multiple hypotheses can be developed and social workers can increase available assessment and treatment options, reducing the reliance on one view point. This process is a clear safeguard against socially constructed perceptions directing outcomes, enabling the worker to reflect upon different decisions and choose the most effective.

The participants reported that their discomfort regarding asking OAs about their alcohol use may be lessened by integrating questions about alcohol into standard health assessments. Why participants do not screen every OA was not evident from the interviews. Further investigation could explore whether participants' feeling uncomfortable asking OAs about alcohol, was derived from their personal perceptions or a lack of training and / or lack of critically reflective supervision.

On the whole the participants demonstrated they were aware of a range of risks regarding OAs and alcohol use. This understanding compared favorably with established literature, an exception being the physiological changes experienced by OAs which participants were not aware of. Surprisingly only two participants highlighted the risks of combining medications and alcohol, setting the context for some participants not seeing alcohol or medications as part of their role responsibilities. This finding was unexpected and may be a result of working in a hierarchical, medically dominated, health setting and / or low awareness of the health impacts of alcohol as a drug. Evidence suggests social workers should be considering both alcohol and medications as part of assessment responsibilities. Further research could look at whether the findings in this study could be replicated in other parts of New Zealand, adding weight to what has been discovered here. Clearly the impact of perception based practice is not unique to this

study and consideration needs to be given as to the reasons for this practice being common place in health settings.

Current assessment tools are not designed for OAs and participants had little knowledge of tools designed for the OA. Addressing perceptions via education, developing multiple hypotheses, challenging assessment bias and including alcohol in standard health assessments would contribute to participants feeling confident in asking OAs about alcohol use and leading best practice regarding working in partnership with wider health systems. Addressing practical issues such as culturally appropriate clinics and access would also ensure OAs needs are more effectively assessed.

In summary, most of the participants do not ask OAs about alcohol as a general rule. It appears participants are products of a wider system that offers little by way of training or robust supervision regarding this subject, resulting in a reliance on perception based practice. An increase in awareness and knowledge via training would support progress towards an evidence informed practice approach. This shift is described by this study as ‘perception to standard question’.

Conclusion

This chapter has discussed the study’s findings, and made connections to and identified differences from, the established evidence in relation to the four aims of the study. Those aims are to: establish whether participants ask OAs about alcohol use, explore whether socially constructed perceptions of OAs contribute to participants’ ability to assess alcohol use of OAs, establish training levels regarding OAs and alcohol use and establish whether agency assessment tools support participants to ask OAs about alcohol use. This conclusion will consider each of these aims in turn.

Aim One: Establish whether participants ask OAs about alcohol use.
The participants in this study did not ask every OA they assessed about alcohol use. Further discussion about why this might be and how to address it is covered in more detail through the other aims below. Future research could seek to discover if this is true of a wider range of RSWs in New Zealand, adding weight to the findings of this study. What is known is that alcohol use by OAs in New Zealand is increasing, health based services need to be responding to this change.

Aim Two: Explore whether socially constructed perceptions of OAs contribute to participants' ability to assess alcohol use of OAs.

This study is the first in New Zealand to establish how socially constructed perception based practice approaches impact on and do not support participants in asking OAs about alcohol. This evidence is presented in a number of ways: participants were influenced by the values and experiences they grew up with and stereotypes. This included the appearances of OAs, how they behaved and the fact they should be treated the same as other age cohorts. Participants allowed perception based practice to influence their decision making, possibly affecting the outcome of assessment processes.

Aim Three: Establish training levels regarding OAs and alcohol use.

No participants had undertaken any specific training regarding OAs and alcohol. Education and knowledge is evidenced as being fundamental to challenging attitudes and perceptions influencing social work practice. A lack of education and knowledge is putting social workers at risk of not working to the required Code of Ethics and the social work professional at risk of losing credibility. What is required is post graduate training regarding OAs and alcohol and robust supervision to: challenge perception based practice, develop multiple hypotheses, challenge assessment bias and include alcohol in standard health assessments to support a move to evidence informed practice. Further research is required to establish what extent these issues are relevant to other RSWs working with OAs in New Zealand and to what extent post graduate training needs to be addressed.

Aim Four: Establish whether agency assessment tools support participants to ask OAs about alcohol use.

The findings related to this aim are broader than just assessment tools, also included are practical and wider health system considerations. Current tools employed in participant's places of employment do not support them asking OAs about alcohol use. Integrating alcohol based questions into standard health assessments would support participants in asking OAs about alcohol related issues and would support a move towards an evidenced informed approach of asking all OAs about alcohol use. This study presents this approach as 'perception to standard question'. Practical issues such as transport and ensuring assessment clinics are welcoming for OAs were important for completing successful assessments. Participants recognise the impact of wider system perceptions of OAs but did not demonstrate ability to challenge these perceptions.

Some of the study's findings were surprising, for example, participants did not see alcohol and medication as areas of responsibility, and the degree to which perceptions impacted on decision making. In order to move beyond what has been identified in this study as 'perception based practice', where often a single hypothesis is developed by the social worker and initial assumptions not challenged, towards an evidenced informed approach including ethical practice and consistent robust assessment tools education and supervision should be developed specifically to address alcohol use by the OA. Otherwise OAs are at risk of less than optimal outcomes from services and social workers are at risk of losing credibility when instead they could be seen as leading practitioners in terms of OAs and alcohol use. This process could be termed a 'perception to standard question' approach.

Having discussed these findings in relation to established evidence the conclusion chapter will present a range of information, implications and recommendations to support a way forward towards implementing evidence informed practice approaches for working with OAs and alcohol in New Zealand.

Chapter Six: Conclusion and recommendations

Introduction

This chapter demonstrates how the research aims have been addressed and provides recommendations for the improvement of social work practice regarding OAs and alcohol use. There is a particular focus on assessment processes.

The chapter is in five sections. The first is a brief summary of the study's methodology. Next the key findings are presented with details of how they align with and extend beyond the original research aims. The third section covers the implications and recommendations for social work practice, and improvement of the assessment of OAs' alcohol use. The fourth highlights areas for future research. Finally, the researcher's own journey is touched on in the conclusion.

Methodology

This study employed a qualitative approach called grounded theory method (GTM), to ensure the focus was on meanings, rather than measures. This was considered appropriate given social work assessment is part art, part science. The meanings explored included each participant's own framing of socially constructed perceptions and ageism, and how these impacted on the way they carried out assessment processes.

Semi-structured interviewing was used for data gathering since its flexible nature allowed the interviewer to change direction to follow the conversation. Each participant interview lasted between 45 and 75 minutes; all interviews were recorded and transcribed by the researcher.

GTM afforded the opportunity to compare data with data and in turn with established literature, creating robust outcomes from triangulation.

Participants presented as honest, trustworthy and passionate regarding the subject matter.

Key Findings

The following six findings have been derived from taking the interview findings and adding learning from the literature. They display the development of thinking throughout this piece of work:

1) Participants' use a **'perception-based approach'** to guide their decision making regarding OAs' alcohol use, despite being aware perceptions influenced their practice.
2) No participants had received any training regarding OAs and alcohol use, or discussed having adequate supervision.
3) Some participants did not see assessing alcohol use, medication or the interaction of alcohol with medication as part of their responsibilities as a social worker.
4) Practice would be improved by implementing an **'evidence informed'** approach regarding assessment tools, assessment outcomes would improve and social workers would be more likely to be working in accordance with the Code of Ethics in a credible, professional manner. No participants used assessment tools specifically designed for the assessment of alcohol use by OAs,
5) Integrating alcohol related questions into standard assessments would improve the number of OAs being assessed and would support a move to an 'evidenced informed' approach. In health settings, this can be described as an emerging theme of moving from **'perception to standard question'**.
6) Implementing 'evidence informed' practice would contribute to social work being a profession leading best practice and challenging wider health system perceptions.

The first finding is that the participants demonstrated several ways in which their practice was underpinned by a 'perception based' approach. As a group they did not consider OAs to be alcohol users. This perception was not supported by the established evidence. The physical appearance of OAs impacted on participants' decision making and whether they asked about alcohol use. They also held perceptions of OAs' behaviours, which would continue to perpetuate ageist beliefs in society. Overall the participants' socially constructed perceptions, gathered from their personal experiences and media, drove their decision making.

The second finding was that none of the participants had received any training or robust supervision regarding OAs and alcohol use. This contributed to: not feeling confident to challenge theirs or others perceptions, not developing alternative hypotheses, and not ensuring assessments were not reliant only on initial information gathered. The participants were products of a health system that offered no education regarding this subject, so a lack of knowledge and confidence is understandable in this context. Participants did demonstrate some knowledge regarding differences in presentations between the genders, physical risks and some patterns of alcohol use, but lacked knowledge that could help in successfully assessing

other possible risks to OAs, such as safe drinking levels and the impact of physiological changes.

Thirdly, surprisingly for health based social workers, some participants did not see assessing alcohol or its interaction with medication as part of their responsibilities. Rather these issues were seen as being within a medical scope of practice. This finding is not supported by the established literature which notes that assessment of alcohol and medication is a clear responsibility within the social work role (Galvani 2015).

The fourth finding is that the implementation of an 'evidence informed' approach supported by robust assessment tools, would improve social work practice and outcomes for the person being assessed. None of the participants used assessment tools containing alcohol as a standard question, or tools that were specifically designed to meet the needs of OAs. Current agency assessment tools do not support participants to ask OAs about alcohol use. The established evidence demonstrates that using a suitable assessment tool would ensure OAs' risks and needs are effectively assessed and would establish social work as a profession leading best practice in this area.

Fifth, the integration of questions regarding alcohol into standard health based assessments would improve the numbers of OAs being assessed and assessment outcomes. The participants believed this would be an effective approach, but did not demonstrate this themselves by asking every OA about their alcohol use - possibly as a result of perceptions driving their practice. Adopting an approach of routinely asking each OA they see about their alcohol use is described in this thesis as an emerging model of 'perception to standard question' approach.

The sixth finding is that by implementing an evidence informed approach, participants can lead best practice and challenge wider health practitioners' perceptions. Current assessment tools and also practical approaches (such as allowing enough time) do not support participants to effectively assess OAs. Undertaking practical improvements, such as improving access to services would ensure social work is leading best practice.

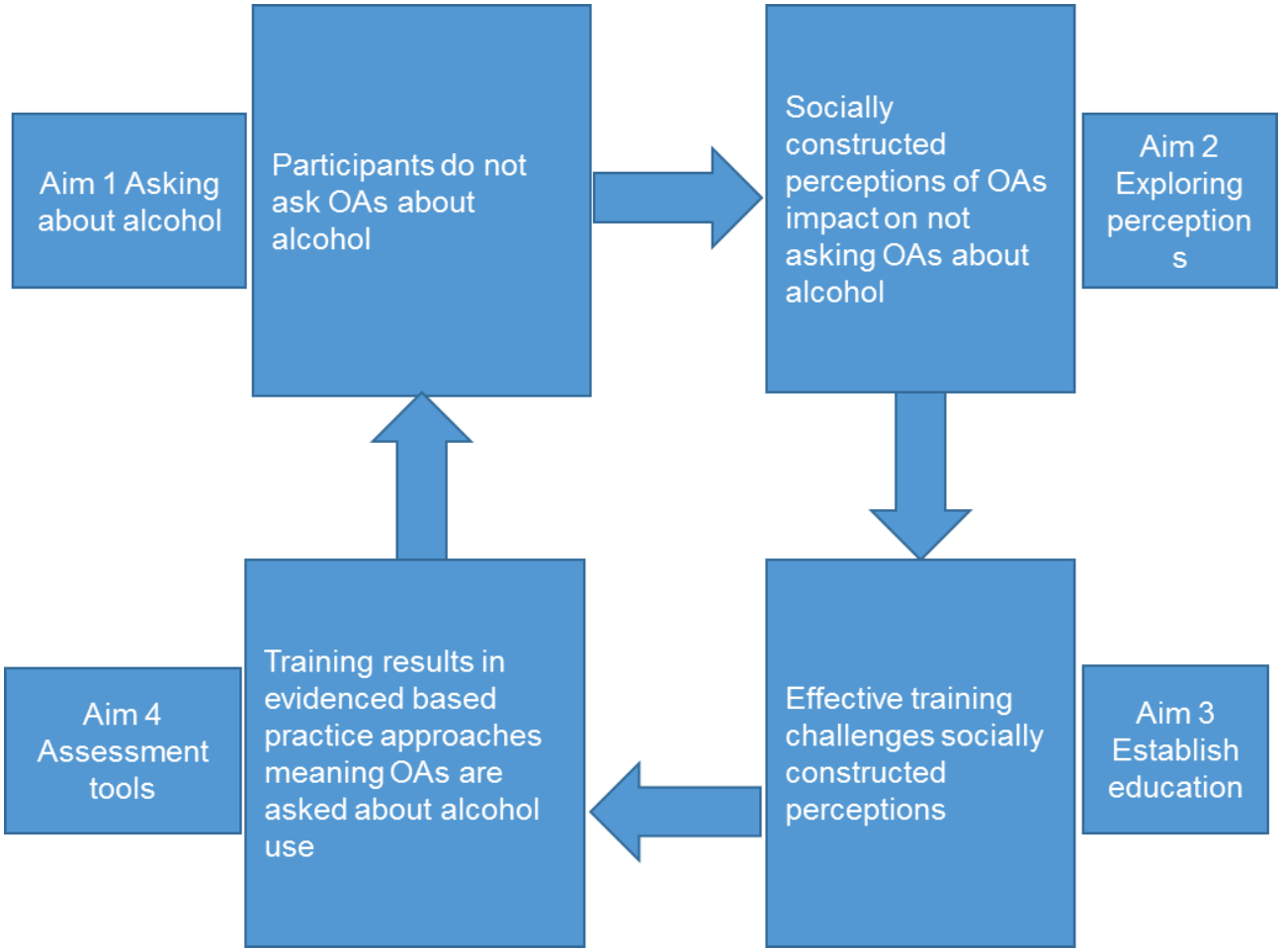
Implications for social work practice and recommendations

Several implications for social work practice and recommendations are now suggested in response to the findings made in this study. These are discussed as they pertain to: firstly, the

participants and other RSWs working with OAs; secondly the training and education levels of RSWs working with OAs; thirdly, OAs as service users; and fourthly, the role of the Ministry of Health (MOH). Finally, the last group is aimed at other government funded agencies, in this instance District Health Boards (DHBs), the Health Promotion Agency (HPA) and the Social Workers Registration Board (SWRB).

The findings from this research addressed and extended the four aims of this study, all of which are interconnected. This connectedness is demonstrated in 'Figure 4: Interconnected nature of research completed'.

Figure 4: Interconnected nature of research completed



Participants and other Registered Social Workers

The recommendations for participants and other RSWs working with OAs concern the development and application of an 'evidence informed' approach to practice. This would entail, at the most basic level, asking all OAs about their alcohol use as part of standard health assessments – that is, moving from a 'perception to standard question' approach. This move would help to reduce feelings of uncomfortableness experienced by participants of this study.

Extending beyond the basic level entails the development of a far more structured and detailed assessment process, ensuring OAs needs and risks are identified. To ensure a consistent framework for decision making is informed by robust evidence, all RSWs working with OAs require access to established research demonstrating social workers' responsibilities regarding alcohol. One example is Galvani's (2015) *Alcohol and Other Drug Use: The Roles and Capabilities of Social Workers*, which clearly details the role social workers should be fulfilling. Another example is Wadd and Galvani's (2014) *Working with Older People with Alcohol Problems: Insights from Specialist Substances Misuse Professionals and their Service Users*. When combined, these documents cover both the social work role in detecting alcohol use and the risk factors associated with alcohol use by OAs. This research would provide the detailed reasoning for assessment of OAs' alcohol use and cement the expectation that assessment of alcohol is a social work responsibility.

RSWs working with OAs should be required to demonstrate how they integrate their knowledge from the research into practice. This could be achieved in three ways. Firstly, robust supervision would enable discussion of and reflection on how RSWs are integrating research knowledge into practice. This of course would require suitably trained supervisors to be available. Secondly, Practice Standards to guide and direct practice should be developed and integrated into post graduate training. These practice guides could have established links to the 'perception to standard question' approach highlighted in this study. Thirdly, SWRB Practicing Certificates are awarded on the basis of submission of competency demonstrated via training. All RSWs working with OAs should in the course of a five-year registration period demonstrate learning in this area. There would be barriers to moving to this third approach. These include: firstly, if this is in place for OAs and alcohol then why not for several other practice areas? Secondly, there are challenges defining whose practice would be required to meet this criterion. Thirdly, how long would a RSW need to work in this field to meet the requirements? Fourth, what is the required level of training undertaken?

Asking every OA about their alcohol use, through a standard assessment, creates an initial screening process that would entail assessment forms being altered to include alcohol based questions. Education would be needed first to ensure the reasons for this change are understood. Initial screening needs to be supported by a second more structured and systematic assessment tool for more detailed information gathering. This ensures the RSW will not be allowing their initial assessment bias alone to determine outcomes. An effective assessment tool, that recognises OAs needs regarding issues such as age-related physiological changes and medication use, is required if this is to be successful. An example of such a tool is the Alcohol Related Problems Survey (ARPS). This tool is specifically designed for OAs, and has been validated for an Australian market. Work is underway to complete this for New Zealand. The MOH should lead the development of this work. A planned program of cross sector work including experts from universities, DHBs, peak bodies, Non-Government Organisations and service users would ensure a successful implementation took place.

Regarding on-going practice, robust supervision of RSWs working with OAs would enable continued reflection on how they undertook assessments and integrated research into their practice. Checklists designed to address any of the RSW's perceptions remaining in place should also be used. A culture of ongoing discussion of the available evidence, such as that listed above, would ensure both supervisors and supervisee remain current both in thinking and practice. It would assist RSWs to develop the ability to reflect and apply learnings and address issues such as participants feeling it was too intrusive or shameful for the OA to be asked about drinking. Robust supervision will only be available if supervisors are suitably knowledgeable in this area. This should be regulated by social work leaders only approving supervisors working with OAs, who have themselves completed post graduate training in the areas covered in this study. To achieve this, secondary health professional leaders would need to maintain a register of suitably qualified supervisors. There are implementation issues to overcome of course but each Allied Health department within District Health Boards should be maintaining a register of suitably qualified supervisors.

Training and education levels

No participants in this study had received training regarding OAs and alcohol use which contributed to perception based approaches being the norm. Some of those perceptions included: whether OAs were seen as alcohol users, and how appearance and behaviour affected decision making. Education designed to drive a move to evidence informed approaches

to practice would ensure OAs needs and risks are better identified and mean participants would overcome feelings of asking about alcohol being too intrusive. An evidence informed approach would entail the creation of multiple hypothesis and continued review of data gathered, resulting in a more effective assessment. That assessment would consider, as examples: physiological changes, safe drinking levels and gender differences. Continuous revising of information would enable more effective assessment of dynamic risk factors, and decision making in the context of a changing environment. Study participants and all RSWs should also develop cross profession collaborations which would help to lessen the impact of the negative perceptions of social work held by other professions and barriers to practice created by the wider health system. Study participants and RSWs need to remain aware of the environmental and cultural needs of OAs, what service provision is best suited to achieve successful outcomes, and seek ways of implementing them. Overall, this creates a clear and defined 'social work' approach to assessing OAs and alcohol.

The first recommendation is for participants and all RSWs working with OAs to have access to established literature as discussed above. Employers could be responsible for ensuring this information is readily available. Participants and RSWs are responsible for reading it, and supervisors are responsible for discussion in supervision regarding understanding and integration into practice. RSWs are also required to maintain continuing professional development which would support this requirement. Secondly, RSWs should ask all OAs about alcohol use as part of standard health assessments, supporting a move from a 'perception to standard question' approach. This is achieved in four ways: firstly, through the implementation into graduate, post graduate and specialist training programs. Training providers should review current curriculums and Health Workforce Development (within the Ministry of Health) should design and implement a post graduate training program. Alongside post graduate training would need to sit Practice Standards to ensure RSWs working with OAs are practicing to an acceptable level of competency. Secondly, supervisors of all RSWs working with OAs should actively challenge their perceptions. Formal checklists for supervision should be considered which include: understanding your perceptions, the origins of those perceptions and how this impacts on your practice. Thirdly, initial local assessment tools should contain alcohol based questions and a nationally consistent tool is required to gather more detailed information. As explained, the MOH should lead the development of such a tool. Finally, all RSWs should consider how to develop collaborative relationships with other health professionals and ensure the environmental and cultural needs of OAs are addressed.

OAs as service users

OAs as service users should be asked about their alcohol use each time they present. This may cause some distress initially, but would eventually become part of standard health assessment processes. This would need to be aided by ensuring enough time is allocated for the building of effective rapport. In the context of an increase in the numbers of OAs using alcohol, this is 'future proofing' secondary health services to be able to adapt to the changing demographics around OA population increase. Increased education for RSWs would result in an improvement in awareness about OAs alcohol use, ensuring needs are effectively assessed. Alongside this is a need for OAs to be informed that they will be asked about their alcohol use and the reasons for this. This should take the form of an information sheet being available to OAs on presentation to services. This ensures these questions will eventually become integrated into usual health services for this cohort. OAs themselves would adapt to these questions being asked as part of standard health assessments, decreasing any feelings of intrusiveness and discomfort. The clear recommendation here is for health services to future proof themselves by ensuring all OAs are asked about alcohol use.

Other successful approaches for engaging OAs were also demonstrated in this study, such as ensuring OAs themselves are employed to work alongside their peers who present to services. This approach has evidence of being successful. If this is not possible the use of volunteers in different settings should be explored. In addition, thought needs to be given to how health service environments can be improved for the OA. This includes practical considerations such as transport and access to services.

The Ministry of Health

The recommendations above have implications for the Ministry of Health, as funders of DHB services. The MOH should be responsible for directing that all OAs are asked about their alcohol use. This would require MOH's Health of Older People group to approach Directors of Allied Health (DAH) within DHBs to ensure such questions are included in all assessments of OAs, (this approach being similar to Family Violence screening already in place). Approaching DAHs would ensure this work reaches further than just social work departments, increasing the breath of coverage.

Assessments of OAs, as demonstrated by this study, are sometimes driven by perceptions that may result in incorrect outcomes. Therefore, data gathered regarding the numbers of OAs using alcohol may also be incorrect. Once a suitable assessment tool is being used to determine

whether an OA is at risk from the level of alcohol they consume the MOH should consider gathering correct data nationally. This would ensure funding for this cohort and any associated services, is allocated accordingly.

Other government funded agencies

Finally, there are implications and recommendations for other government funded agencies, with the majority of these falling to DHBs as employers. Firstly, RSWs working with OAs need to have access to current literature as discussed above. Secondly, an increase in the time allowed for both initial and detailed assessments would increase the quality of services provided. An area of concern will be the increased demand on services simply from identifying extra areas of intervention (and generally because the population is ageing). The comment above regarding the appropriate placement of funding is relevant here. Using an improved assessment tool will increase the number of OAs identified as requiring intervention. This will result in an increased need for resource, particularly because OAs frequently require extra time to benefit from interventions. In contrast, more accurate information could also be used to limit access to resources. Analysis would need to be undertaken to demonstrate the degree of extra resource required as standard assessment times for this cohort is not currently well evidenced.

Thirdly, there is a need for an increase in and improvement of, available information regarding the impact of alcohol for OAs. This has implications for the Health Promotion Agency (HPA) who are responsible for producing the relevant information. This information is currently absent in New Zealand and requires addressing urgently.

Finally, is the area of RSW registration competency levels, which are the responsibility of the SWRB. Practicing Certificates are issued on the basis of completion of required numbers of training hours, and the ability to relate these hours to practice improvements. The SWRB should require all RSWs working with OAs to display evidence of completion of all Practice Standards resulting from post graduate training as evidence of competency to work effectively with OAs.

Future research

This study has identified a number of areas requiring further research. First would be expanding many of the questions asked in this study to a wider group of RSWs to gain a New Zealand wide understanding of current practice. For example, do RSWs working in health settings ask OAs about alcohol use? Is the lack of training found in this study reflective of opportunities

across New Zealand and is this subject seen as important? Do RSWs see the interaction of alcohol and medication as an area within their responsibility? Do RSWs see OAs as a cohort with similar needs and do they take action to ensure these needs are effectively met? Do RSWs across New Zealand display the specialist skills identified as needed in this study? Do RSWs feel confident in challenging wider health system perceptions? Do RSWs have time to build effective rapport during assessments? Finally, where do RSWs perceptions of OAs originate from and to what degree do their perceptions of OAs impact on RSW decision making?

The question of whether RSWs ask OAs about their alcohol use could be examined as an information gathering exercise sent directly to all RSWs working with OAs via the SWRB registration list.

Secondly, it is important to know if RSWs working with OAs have received training or robust supervision that challenges their thinking regarding alcohol use. Data indicating whether workers are aware of issues such as age appropriate services and the need to ensure access, transport and cultural appropriateness would also be useful. Health Workforce Development within the MOH could complete this using a brief online survey via DHBs as employers. The extent of post graduate training required across New Zealand could also be established in this way. Completing this for all allied health staff would also provide an understanding of whether the subject is given wider health system importance. Further information gathered via this process could include whether RSWs and allied health staff use checklists or other systems to prevent initial assessment bias or reliance on a single hypothesis during assessments.

A third area for further research would be whether RSWs working with OAs see alcohol and medications as part of their responsibilities. HPA could undertake this work in partnership with Directors of Allied Health at DHBs, therefore including other parts of the allied health workforce in an online survey. Expanding the research to include allied health would indicate whether the whole approach to alcohol within allied health needs to be re-considered or whether this study's findings were solely relevant to the participants in this piece of work. Consideration of whether an emerging approach of 'perception to standard question' could be applied to the assessment of OAs and alcohol use, on a national basis, should also be included.

Conclusion

This thesis has explored eight registered social workers' understanding of OAs' alcohol use and alcohol assessment processes. This is a unique piece of research in New Zealand, as the study aims have not been explored in relation to social work previously.

The four aims of the study were to: 1) establish whether participants ask OAs about alcohol use, 2) explore whether participants' socially constructed perceptions of OAs impacted on assessment processes, 3) establish what training participants had undertaken in this area, and 4) establish whether agency assessment tools supported participants in asking OAs about their alcohol use.

Several significant findings were developed in relation to each of the four aims. These included that the participants did not regularly ask OAs about alcohol use, perceptions played a significant part in participants' decision making, no participants had undergone any training in this area and assessment tools were either unknown to participants or not supportive in asking OAs about alcohol use. There were also many significant findings outside of the main aims. For example, participants did not see alcohol as an area within their responsibility, and practical considerations such as access and transport to services were important to ensure good outcomes were achieved.

The degree to which participants' decision making was impacted by 'perception based' practice requires further research and demonstrates the impact of participants not having any training in the subject matter and appropriate assessment practice. Participants' views of alcohol not being a social work responsibility are concerning as is the lack of knowledge regarding assessment tools. Ongoing robust supervision is required alongside initial training to ensure an individual's perceptions of OAs do not continue to influence health based social workers' decision making.

The difference between 'evidence informed' and 'evidenced based' practice was presented as part of this study's introduction. The findings indicate that 'evidence informed' approaches better suit social work concerning alcohol and OAs. There is not the 'hierarchy of evidence' required to make an argument that this work is evidence-based, and social work is part art, part science by nature. A further connected example is that of prescriptive practice verses practitioner autonomy. This is interesting because an evidence informed approach allows a degree of autonomy in practice, while arguing for set questions to be built into assessment tools moves

RSWs in the direction of prescriptive practice. The emerging approach of ‘perception to standard question’ described in this thesis would seek to form a balance between these two points. Affording the social worker the ability to be creative with questions asked while still ensuring basic formats are covered. This study employed a qualitative methodology, as participants’ experiences were explored in some depth. Grounded Theory Method was used, which entailed significant personal learning for the researcher. Using semi-structured interviews was effective for gathering relevant data which focused on participants understanding and feelings of the subject being researched - meaning rather than measurement. Using open coding enabled detailed knowledge of the data to be developed and clearly understood, and provided an opportunity to develop a new assessment approach of ‘perception to standard question’.

This piece of research has entailed a significant journey for the researcher. Before beginning this thesis my personal levels of knowledge compared comfortably to the participants of this study. My awareness of the heightened risks of alcohol for OAs, even at lower levels of use, was very low and I had given little thought as to how OAs are perceived by health professionals. Completing this piece of research has provided a real learning opportunity, with my subject knowledge increasing significantly. My awareness of my own perceptions regarding OAs has developed and my assumptions about OAs being a homogenous cohort have been challenged. Prior to completing this work my consideration of OAs as a cohort with a wide range of differing needs was minimal. Without this awareness, we are all contributing to perpetuating ageism and socially constructed perceptions of OAs. While having had some experience of assessing OAs’ use of alcohol I was surprised to find that socially constructed perceptions impacted on participants’ decisions to such a degree, resulting from a lack of any education and training, and an absence of consistent and effective assessment tools.

This study has achieved what Clough and Nutbrown, (2012, p. 25) claim is the main outcome of research; “Question assumptions and perceptions which are taken for granted in everyday life”. Exploring OAs and their alcohol use has resulted in a number of significant recommendations to improve social work assessment practice not previously considered in New Zealand. It has in many ways also reflected and had connections to, wider issues or debates within the social work profession, for example the role of social work in a predominately medically led health environment.

Difficulties resulting from alcohol use are a pervasive social issue across New Zealand, affecting people from all walks of life and ages. Registered social workers are ideally placed to breakdown taboos, support people to address difficulties arising from their use, and ultimately to improve our relationship with alcohol in New Zealand.

The intention is that findings from this work will lead to the completion of articles for publishing on: the impact of perceptions about OAs on social work practice, education regarding OAs and alcohol, OAs as a unique cohort, and the emerging approach of ‘perception to standard question’. Further study focusing on the ‘Future Research’ areas identified above will also be considered.

Recognition should be given to the participants in this study. Thank you for providing such an abundant amount of rich and interesting information and for remaining committed to improving the practice of social work in New Zealand.

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Appendix 1: Assessment Tools

Alcohol Use Disorders Identification Test (AUDIT)
Full version of this framework consists of 10 questions which are designed to identify people who drink in a risky manner, questions are designed to identify both frequency of drinking and dependency signs (Hodges & Maskill, 2014). AUDIT can be administered by a health professional or be self-completed as an initial assessment tool to identify the need for further intervention (Barbor et al., 2001). Questions are given a rating, with an overall value of 40 (see appendix 1 for a copy of screening tool). Generally a score of eight or above is highlighted as an indicator of harmful drinking (Barbor et al., 2001). Outcome scores however often vary depending on the population being assessed (Hodges and Maskill, 2014). There are no questions that take a different presentation such as older age into consideration.
AUDIT-C
Audit – C utilises the first three questions of the AUDIT tool as a shortened version of the AUDIT tool. The three questions have a maximum score of 12. The original researchers stated this score captured 98% of heavy drinkers (Hodges & Maskill, 2014). Further research has recommended lower thresholds for group such as women (Towers et al. 2011).
CAGE
The CAGE alcohol screening tool was developed in 1968 by J, A, Ewing (1968). It should be remembered that it is only designed as an initial screening tool and anyone demonstrating a positive result should undergo a full clinical assessment (Dhalla & Kopec, 2007). CAGE has been noted for lack of sensitivity. In one study more general questions were used achieving greater results (Stenwig & Worth, 1993). In another older study CAGE demonstrated good ability to distinguish drug and alcohol users from a control group of OAs. However it was also found to lack any degree of diagnostic specificity (Hinkin et al., 2001).

CAGE is based on four questions easily remembered as:

1. Have you ever felt you should cut down on your drinking? (c = cut down)
2. Have people annoyed you by criticizing your drinking? (a = annoyed)
3. Have you ever felt bad or guilty about your drinking? (g = guilty)
4. Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover? (e = eye opener)

Diagnostic and Statistical Manual of Mental Disorders (DSM) - IV and V

DSM IV and V are both used in the diagnosis of hazardous drinking. DSM IV identifies someone as having alcohol abuse by having one of the following indicators:

1. Repeating pattern of use that results in failure to complete required tasks at school, home, work
2. Repeated use in situations that are dangerous- driving, using machinery etc
3. Despite experiencing repeated interpersonal or social difficulties continued used is evidenced

Alcohol dependence is identified if a person meets three of the following criteria:

1. Increased tolerance
2. Withdrawal symptoms relieved by alcohol
3. Consume more, for longer, than intended
4. Unable to cut down or stop
5. Spends long periods of time obtaining, recovering or using
6. Important social, work or other recreational activities are given up for alcohol
7. Use is continued despite evidence of physical or psychological difficulties

DSM V places both dependence and abuse in one category of ‘alcohol use disorder’. This category is made up of 11 presentation related questions and is connected to three sub-categories of: Mild, Moderate and severe.

American Psychiatric Association (2013).

Alcohol – Related Problems Survey (ARPS)
The tools covered above may not be comprehensive enough to identify the needs of OAs, particularly where OAs have additional physical or medical conditions, or poly-pharmacy is current (Hodges & Maskill, 2014). The ARPS tool contains 18 questions and 60 items. The assessment process concentrates on alcohol use but also on a range of physical and mental health factors, medications and general functioning ability (Fink et al., 2005). While the ARPS is designed to assess the needs of OAs criticism of it includes length of time to complete (10mins) and outcomes needing to be analysed using a computer (Hodges & Maskill, 2014). One NZ review concluded the ARPS tool is suitable for assessing the needs of OAs and will become more widely used as computer analysis becomes more widespread in Health settings (Berks & McCormick, 2008). This tool has been trialled in Australia on men and women between the ages of 55- 89. Outcomes indicate it is successful at identifying OAs that may be drinking at harmful levels (Bright, Fink Beck & Gabriel, 2013).
CARET
The Comorbidity Alcohol Risk Evaluation Tool (CARET) is a tool for identifying OAs who drink at hazardous levels, it is a shortened version of the ARPS containing many of the same co-morbidity, physiological and medication features so important when assessing OAs. The CARET takes 2- 5 minutes to self- administer (Moore et al., 2012). One study used the CARET as part of a mailed assessment trial. Focusing on adults aged 50 years plus and identified via a CARET assessment for baseline this study sought to establish whether mailed screening tools could be effective for this cohort. Results indicated that a stand-alone mailed assessment process was an effective way of identifying OAs who drink in a hazardous manner. While recognising that OAs should ideally be routinely screened for alcohol use, this study realistically indicated this rarely took place due to lack of time and the uncomfortableness of asking OAs (Kuerbis, Hagman & Sacco, 2015).

InterRAI
New Zealand Government has selected InterRAI to assess OAs needs and strengths, particularly regarding Aged Residential Care. InterRAI collects data using a common assessment tool focusing on the needs of the person being assessed. This tool has been identified to best meet the needs of OAs in New Zealand (New Zealand Guidelines Group, 2003), and many countries around the world (Morris et al., 2010). InterRAI includes questions around alcohol use, pointing out that detection rates among OAs. There are connections between alcohol and atypical features such as falls, depression and confusion. If an issue regarding alcohol use is identified InterRAI recommends an approach based on the CAGE model (covered above). Co-morbid health conditions are also considered highlighting that if multiple medications are being taken consumption may need to be minimal or nil. There is little mention of how an OAs physiological changes may affect the impact of alcohol use itself but connections to other factors such as depression are covered. InterRAI New Zealand (2014) recommends referral to a specialist for alcohol dependency intervention and possible inpatient treatment to manage withdrawal symptoms (Morris et al., 2010).
The Michigan Alcohol Screening Test (MAST)
The MAST tool, developed in Michigian USA in 1971, is not only one of the oldest alcohol screening tools but claims to be one of the most accurate (up to 98%). It has 22 questions which focus on the users self-assessment of heavy drinking that impacts on vocational, social and family difficulties. The tool was developed for the general population. Two challenges of it are that use is fairly time consuming and it focusses on lifetime difficulties rather than current presentations. Very Well (2016) https://www.verywell.com/the-michigan-alcohol-screening-test-69497

Short Michigan Alcohol Screening Test-Geriatric Version (SMAST-G)
This shorter version of the MAST tool was develop specifically to address OA drinkers. It asked 10 (plus one extra) questions. Like many tools it does not really highlight risks relevant to physiological changes, multi-medications or age related illnesses. Vermont Department of Health http://sbirt.vermont.gov/screening-forms/older-adult-alcohol-screening-instrument/

Appendix 2: Ethics Application and approval

Human Ethics Application

FOR APPROVAL OF PROPOSED RESEARCH/TEACHING/EVALUATION INVOLVING HUMAN PARTICIPANTS

(All applications are to be typed and presented using language that is free from jargon and comprehensible to lay people)

SECTION A

1 Project Title Older adults and alcohol: A study of registered social workers assessment practices

Projected start date for data collection September 2015 **Projected end date** December 2015

(In no case will approval be given if recruitment and/or data collection has already begun).

2 Applicant Details *(Select the appropriate box and complete details)*

ACADEMIC STAFF APPLICATION (excluding staff who are also students)

Full Name of Staff Applicant/s

School/Department/Institute

Campus *(mark one only)* **Albany** ☐ **Palmerston North** ☐ **Wellington** ☐

Telephone **Email Address**

GENERAL STAFF APPLICATION

Full Name of Applicant

Section

Campus *(mark one only)* **Albany** ☐ **Palmerston North** ☐ **Wellington** ☐

Telephone **Email Address**

Full Name of Line Manager

Section

Telephone **Email Address**

3 Type of Project *(provide detail as appropriate)*

Staff Research/Evaluation: ☐ **Student Research:** ☐ **If other, please specify:**

Academic Staff		**Specify Qualification**	✓	**Master of Social Work**
General Staff		**Specify Credit Value of Research**	✓	**120 credits**
Evaluation		**(e.g. 30, 60, 90, 120, 240, 360)**		

4 Summary of Project

Please outline in no more than 200 words in lay language why you have chosen this project, what you intend to do and the methods you will use.

(Note: All the information provided in the application is potentially available if a request is made under the Official Information Act. In the event that a request is made, the University, in the first instance, would endeavour to satisfy that request by providing this summary. Please ensure that the language used is comprehensible to all.)

Alcohol use / misuse remains an invisible problem of older adults (OAs) (McInnis-Dittrich 2014). Health professionals frequently fail to include questions regarding alcohol use / misuse when assessing the needs of OAs (Christie, Bamber, Powell, Arrindell, & Pant, 2013). There is no general agreement on at what age a person becomes old (Morrison, 2012). This research recognises 65 years is commonly used as an indicator of older age.

This study will explore whether New Zealand (NZ) Registered Social Workers (RSWs), ask OAs about alcohol use / misuse as part of assessment processes, whether they have received training in this area and whether agency assessment tools facilitate such questions. Evidence suggests socially constructed perceptions of OAs, such as refusals to believe OAs can drink in harmful ways (Wadd, & Galvani, 2014), contribute to reluctance in assessing alcohol use / misuse of this cohort. This research will explore RSWs perceptions in this regard.

The participants in this research will be RSWs who have assessed an OAs needs and live in an urban region in the Lower North Island of NZ. The research will be a qualitative piece of inquiry that uses six to eight semi-structured interviews with participants who meet required criteria.

5 **List the Attachments to your Application**, e.g. Completed "Screening Questionnaire to Determine the Approval Procedure" (compulsory), Information Sheet/s *(indicate how many*), Translated copies of Information Sheet/s, Consent Form/s *(indicate of how many)*, Translated copies of Consent Form/s, Transcriber Confidentiality Agreement, Confidentiality Agreement *(for persons other than the researcher / participants who have access to project data)*, Authority for Release of Tape Transcripts, Advertisement, Health Checklist, Questionnaire, Interview Schedule, Evidence of Consultation, Letter requesting access to an institution, Letter requesting approval for use of database, Other *(please specify).*

- Screening Questionnaire to Determine the Approval Procedure (Appendix A)
- Initial letter to Social Workers Registration Board (Appendix B)
- Draft email from SWRB to RSWs (Appendix C)
- Participant Information sheet (Appendix C)
- Participant consent form (Appendix D)
- Interview schedule (Appendix E)
- Authority to release transcripts (Appendix F)

Applications that are incomplete or lacking the appropriate signatures will not be processed. This will mean delays for the project.

Please refer to the Human Ethics website (http://humanethics.massey.ac.nz) for details of where to submit your application and the number of copies required.

SECTION B: PROJECT INFORMATION

General

6	**I/We wish the protocol to be heard in a closed meeting (Part II).** *(If yes, state the reason in a covering letter.)*	**Yes**		**No**	✓
7	**Does this project have any links to previously submitted MUHEC or HDEC application(s)?** **If yes, list the MUHEC or HDEC application number/s (if assigned) and relationship/s.**	**Yes**		**No**	✓
8	**Is approval from other Ethics Committees being sought for the project?** **If yes, list the other Ethics Committees.**	**Yes**		**No**	✓
9	**For staff research, is the applicant the only researcher?** **If no, list the names and addresses of all members of the research team.**	**Yes**		**No**	

Project Details

10 State concisely the aims of the project.

The aim of this research will be to:

- establish whether RSWs ask OAs about alcohol use;
- explore whether socially constructed perceptions of OAs contributes to RSWs ability to assess alcohol misuse of OAs;
- establish training levels regarding OAs and alcohol use;
- establish whether agency assessment tools support the RSW to ask OAs about alcohol use.

11 Give a brief background to the project to place it in perspective and to allow the project's significance to be assessed. *(No more than 200 words in lay language)*

The extent to which health workers are uncomfortable asking OAs about alcohol is unknown. Many may lack training to identify this issue or may not be aware of the extent of the problem (Taylor, Jones & Denning 2014). Most Allied Health staff have no training regarding OAs and alcohol misuse (Waldon, & McGrath, 2011).

'Baby boomers' (adults born 1946-1964) use more alcohol than generations before (Babatunde, Outlaw, Forbes, & Gay, 2014). This cohort is increasing in size: People 65 years plus are predicted to make up over 25% of the population by the end of the 2030's. In 2005 it was 12% (Statistics New Zealand, 2006).

Alcohol misuse by OAs can lead to health disadvantages of greater impact than in younger populations (Jenkins, & Zucker, 2010). OAs can receive interventions for physical conditions caused by alcohol, such as a fall, rather than alcohol treatment (Wadd, Lapworth, Sullivan, Forrester, & Galvani, 2011).

This context provides the background for exploring the landscape of RSWs socially constructed perceptions regarding OAs and alcohol and establishing whether participants ask alcohol related questions during assessment processes. Exploring the training experiences of RSWs in NZ will provide locally based knowledge in this area.

12 Outline the research procedures to be used, including approach/procedures for collecting data. Use a flow chart if necessary.

1. Student researcher will make contact with Social Workers Registration Board (SWRB) to request they pass on the research details directly to Registered Social Workers (Appendix A).
2. SWRB will email all RSWs working in the identified region an initial request and participant information sheet (Appendix B and C).
3. Interested participants will be asked to make direct contact with student researcher.
4. The student researcher will then agree a convenient time and location with the participant to conduct the interview.
5. Participants' views will be gathered during a semi-structured interview.
6. If consent is given these interviews will be recorded via digitally recorded means. If approval is not given the student researcher will record in writing.
7. Student researcher will transcribe the recordings.
8. Participants will have an opportunity to confirm the contents of the transcription and confirm release of their interview.
9. The results will be analysed using qualitative research methods; The data will be analysed through a close reading of the transcripts in which the themes present will be identified, compared and contrasted using thematic analysis.

13 Where will the project be conducted? Include information about the physical location/setting.

The interviews will be conducted at a time and location convenient to participants. A large urban region in the Lower North Island of New Zealand will provide a catchment area for this project.

14 If the study is based overseas:

i) Specify which countries are involved;

ii) Outline how overseas country requirements (if any) have been complied with;

iii) Have the University's Policy & Procedures for Course Related Student Travel Overseas been met? *(Note: Overseas travel undertaken by students – refer to item 5.10 in the document "Additional Information" on the MUHEC website.)*

N/A

15 Describe the experience of the researcher and/or supervisor to undertake this type of project?

The student researcher has 25 years' experience in social work and has undertaken several projects where the views of social workers have been gathered through interviews. These experiences have provided the necessary skills to develop rapport with social workers within ethical and safe guidelines and practice in a non-judgemental and open manner.

The student researcher will be employing a qualitative approach. Qualitative research relies on open ended and in-depth questions with a small number of participants, in this instance 6-8 people. Data is coded using the participants own words to validate themes used (Fortune, Read & Miller 2013).

The student researcher will be supported by two experienced Supervisors appointed by Massey University.

16 Describe the process that has been used to discuss and analyse the ethical issues present in this project.

Ethical issues have been discussed with supervisors as part of thesis supervision. Drafts of this Ethics application has been reviewed by supervisors.

Participants

17 Describe the intended participants.

Criteria to be met for this research:

- RSWs who have assessed an OAs needs (this enables a greater range of potential participants to be contacted, rather than those only currently working with OAs.
- Must be a fully registered RSW (there is no required length of time for registration as a mixture of experience would be useful as this may produce a range of views)
- To be able to conduct an interview in English.
- Work within the required urban region in the Lower North Island.

18 How many participants will be involved?

6-8 Registered Social Workers.

What is the reason for selecting this number?

(Where relevant, attach a copy of the Statistical Justification to the application form)

Time and resource constraints limit the study to this number. This number is considered adequate to provide for the depth of data collection in line with a qualitative approach.

19 Describe how potential participants will be identified and recruited?

Initial participant contact will be made via SWRB. This removes initial direct contact from student researcher to participants.

Student Researcher will inform SWRB of intended research and seek their willingness to pass on the details and information of the research to RSWs that meet required criteria.

Once a RSW has received relevant details and self-selected interest in being a participant, they will be able to contact the student researcher directly via either email or phone.

The student researcher will then arrange a convenient location and time to conduct the interview.

20 Does the project involve recruitment through advertising? **Yes** ☐ **No** ☑

(If yes, attach a copy of the advertisement to the application form)

21 Does the project require permission of an organisation (e.g. an educational institution, an academic unit of Massey University or a business) to access participants or information? **Yes** ☑ **No** ☐

If yes: i) list the organisation(s)

ii) attach a copy of the draft request letter(s) to the application form, e.g. letter to Board of Trustees, PVC, HoD/I/S, CEO etc (include this in your list of attachments (Q5).

(Note that some educational institutions may require the researcher to submit a Police Security Clearance.)

Permission of SWRB is required, a copy of the initial contact letter to this organisation is included (Appendix A).

22 Who will make the initial approach to potential participants?

Initial contact will be made by SWRB. Participants can then self-select if interested in becoming a participant.

23 Describe criteria (if used) to select participants from the pool of potential participants.

Participants will be accepted on a first come first served basis, the first 6-8 respondents who meet the following inclusion criteria will be used:

- RSWs who have assessed an OAs needs
- Must be a RSW (there is no required length of time for registration as a mixture of experience would be useful as this may produce a range of views)
  Be able to conduct an interview in English
- Work within the required urban region in the Lower North Island

24 How much time will participants have to give to the project?

Participants will be expected to participate in up to two hours of activities made up of the following:

- Participants will partake in an initial introduction session where they will be given a chance to ask questions and sign consent forms (Appendix D) this is expected to take approximately 15 minutes.
- Immediately following this they will participate in a semi-structured interview (Appendix E) lasting approximately 60-75 minutes.
- Finally they will asked to review the transcript, correct any errors and sign a release form (Appendix F), this will take place approximately one month later once transcripts have been completed, this is expected to take approximately 30 minutes.

Data Collection

25 Does the project include the use of participant questionnaire/s? **Yes** [ ] **No** [✓]

(If yes, attach a copy of the Questionnaire/s to the application form and include this in your list of attachments (Q5))

If yes: i) indicate whether the participants will be anonymous (i.e. their identity unknown to the researcher). **Yes** [ ] **No** [ ]

ii) describe how the questionnaire will be distributed and collected.

(If distributing electronically through Massey IT, attach a copy of the draft request letter to the Director, Information Technology Services to the application form. Include this in your list of attachments (Q5) – refer to the policy on "Research Use of IT Infrastructure".)

26 Does the project involve observation of participants? If yes, please describe. **Yes** [ ] **No** [✓]

27 Does the project include the use of focus group/s? **Yes** [ ] **No** [✓]

(If yes, attach a copy of the Confidentiality Agreement for the focus group to the application form)

If yes, describe the location of the focus group and time length, including whether it will be in work time. *(If the latter, ensure the researcher asks permission for this from the employer).*

28	**Does the project include the use of participant interview/s?**	**Yes**	✓	**No**	

(If yes, attach a copy of the Interview Questions/Schedule to the application form)

If yes, describe the location of the interview and time length, including whether it will be in work time. *(If the latter, ensure the researcher asks permission for this from the employer)*

The information and interview will take between 75-90 minutes (in total) and will be conducted at a mutually agreed time and place, the researcher will travel to a venue agreed to by the participant.

29	**Does the project involve sound recording?**	**Yes**	✓	**No**	
30	**Does the project involve image recording, e.g. photo or video?**	**Yes**		**No**	✓

If yes, please describe. *(If agreement for recording is optional for participation, ensure there is explicit consent on the Consent Form)*

31	**If recording is used, will the record be transcribed?**	**Yes**	✓	**No**	

If yes, state who will do the transcribing.

The student researcher will transcribe the interviews.

(If not the researcher, a Transcriber's Confidentiality Agreement is required – attach a copy to the application form. Normally, transcripts of interviews should be provided to participants for editing, therefore an Authority For the Release of Tape Transcripts is required – attach a copy to the application form. However, if the researcher considers that the right of the participant to edit is inappropriate, a justification should be provided below.)

32	**Does the project involve any other method of data collection not covered in Qs 25-31?**	**Yes**		**No**	✓

If yes, describe the method used.

33	**Does the project require permission to access databases?**	**Yes**		**No**	✓

(If yes, attach a copy of the draft request letter/s to the application form. Include this in your list of attachments (Q5). Note: If you wish to access the Massey University student database, written permission from Director, National Student Relations should be attached.)

34 Who will carry out the data collection?

The student researcher.

SECTION C: BENEFITS / RISK OF HARM (Refer Code Section 3, Para 10)

35 What are the possible benefits (if any) of the project to individual participants, groups, communities and institutions?

Participants may have an interest in this subject and find it an interesting experience to be part of a research project. Participation may provide an opportunity for reflection on their experience and awareness of this subject.

Participants may feel the subject is concerning and their contribution may go some way to highlight concerns in this area.

This research will contribute to increasing professional knowledge in this area being the first piece of NZ based research focusing on social workers, OAs and alcohol use.

36 What discomfort (physical, psychological, social), incapacity or other risk of harm are individual participants likely to experience as a result of participation?

There may be some minimal risk that participants feel some discomfort arising from discussing their practice, especially if they do not have a positive experience to report.

37 Describe the strategies you will use to deal with any of the situations identified in Q36.

The information sheet and consent form will inform the participants of their right to refuse to answer any question or to withdraw from the study at any stage if they feel uncomfortable, without any consequence.

The student researcher will offer to stop the interview or allow for a break should the participants become uncomfortable at any stage.

No participants will be able to be identified in this study. The student researcher will use pseudonyms to identify participants.

The nature of this study is exploratory and pertains primarily to the questions social workers ask or do not ask in regard to older adults alcohol use. It is highly unlikely that participants would disclose negligent practice in this study in regard to conduct unbecoming of social worker. If I had concerns about any disclosures of this kind I would first take advice from my supervisors who are both registered social workers about my obligations under the SWRB code of conduct.

38 What is the risk of harm (if any) of the project to the researcher?

None is anticipated, however the student researcher will take all reasonable precautions to ensure their physical safety. This includes taking a cell phone so someone can be contacted should they feel unsafe, letting someone know the research plans such as where the researcher is going and how long they intend to be there.

39 Describe the strategies you will use to deal with any of the situations identified in Q38.

Anything that arises will be discussed in depth with thesis supervisors.

40 **What discomfort (physical, psychological, social) incapacity or other risk of harm are groups/communities and institutions likely to experience as a result of this research?**

The research will include exploring assessment tools used in agencies. Assessments that include alcohol use questions can be undertaken in a number of ways from a formal screening tool to simple questions (Matua Raki, 2012).

There are minimal risks of agencies feeling uncomfortable with questions around assessment tools used within their organisation.

41 **Describe the strategies you will use to deal with any of the situations identified in Q40.**

Agencies will not be named or identified within this study. Ensuring agency identification is removed will lessen impact of any negative discussion regarding the format of assessment tools used.

Anything that arises will be discussed with thesis supervisors.

42 **Is ethnicity data being collected as part of the project?** **Yes** ☐ **No** ☑

If yes, please describe how the data will be used.

(Note that harm can be done through an analysis based on insufficient sample or sub-set numbers).

43 **If participants are children/students in a pre-school/school/tertiary setting, describe the arrangements you will make for children/students who are present but not taking part in the research**.

(Note that no child/student should be disadvantaged through the research)

N/A

SECTION D: INFORMED & VOLUNTARY CONSENT (Refer Code Section 3, Para 11)

44 **By whom and how, will information about the research be given to potential participants?**

The SWRB will email all RSWs in the region, providing details of project and required information sheets about the research. This provides information on the nature of the research, the confidential nature of their participation and how the information they provide will be used.

45 **Will consent to participate be given in writing?** **Yes** ☑ **No** ☐

Consent Form attached (Appendix C).

If no, justify the use of oral consent.

46	**Will participants include persons under the age of 16?**	**Yes**		**No**	✓
	If yes: i) indicate the age group and competency for giving consent.				
	ii) indicate if the researcher will be obtaining the consent of parent(s)/caregiver(s).	**Yes**		**No**	

(Note that parental/caregiver consent for school-based research may be required by the school even when children are competent. Ensure Information Sheets and Consent Forms are in a style and language appropriate for the age group.)

47	**Will participants include persons whose capacity to give informed consent may be compromised?**	**Yes**		**No**	✓

If yes, describe the consent process you will use.

48	**Will the participants be proficient in English?**	**Yes**	✓	**No**	

If no, all documentation for participants (Information Sheets/Consent Forms/Questionnaire etc) must be translated into the participants' first-language.

(Attach copies of the translated Information Sheet/Consent Form etc to the application form)

SECTION E: PRIVACY/CONFIDENTIALITY ISSUES (Refer Code Section 3, Para 12)

49	**Will any information be obtained from any source other than the participant?**	**Yes**		**No**	✓

If yes, describe how and from whom.

50	**Will any information that identifies participants be given to any person outside the research team?**	**Yes**		**No**	✓

If yes, indicate why and how.

51	**Will the participants be anonymous (i.e. their identity unknown to the researcher?)**	**Yes**		**No**	✓

If no, explain how confidentiality of the participants' identities will be maintained in the treatment and use of the data.

As the research will be conducted via a face to face interview, participant identity will be known to the researcher. However, all available steps will be taken to ensure confidentiality.

Each participant will be given an identifying code or pseudonym. This will be used from the first interview recording and will be the only means of identifying participants throughout the research project.

The use of a code or pseudonym will enable different views to be identified while ensuring the person's identity remains confidential.

52 **Will an institution (e.g. school) to which participants belong be named or be able to be identified?** **Yes** [ ] **No** [✓]

If yes, explain how you have made the institution aware of this?

53 **Outline how and where:**

i) the data will be stored, and

(Pay particular attention to identifiable data, e.g. tapes, videos and images)

Data will be stored in a password protected computer at the researcher's home.

ii) Consent Forms will be stored.

(Note that Consent Forms should be stored separately from data)

Consent forms will be stored in a locked cabinet at the researcher's home.

54 **i) Who will have access to the data/Consent Forms?**

The researcher and supervisors (if necessary).

ii) How will the data/Consent Forms be protected from unauthorised access?

Only the researcher has a key to the locked cabinet and will not disclose the computer file password to others. Arrangements will be agreed with supervisors regarding how they can gain access if required.

55 **How long will the data from the study be kept, who will be responsible for its safe keeping and eventual disposal? (Note that health information relating to an identifiable individual must be retained for at least 10 years, or in the case of a child, 10 years from the age of 16).**

(For student research the Massey University HOD Institute/School/Section / Supervisor / or nominee should be responsible for the eventual disposal of data. Note that although destruction is the most common form of disposal, at times, transfer of data to an official archive may be appropriate. Refer to the Code, Section 4, Para 24.)

Once the project has been finalised and the thesis has been examined, the consent forms will be shredded and electronic files deleted from the student researcher's computer.

SECTION F: DECEPTION (Refer Code Section 3, Para 13)

56	**Is deception involved at any stage of the project?**	**Yes**		**No**	✓

If yes, justify its use and describe the debriefing procedures.

SECTION G: CONFLICT OF ROLE/INTEREST (Refer Code Section 3, Para 14)

57	**Is the project to be funded or supported in any way, e.g. supply of products for testing?**	**Yes**		**No**	✓

If yes: i) state the source of funding or support:

- **Massey Academic Unit**
- **Massey University (e.g. MURF, SIF)**
- **External Organisation (provide name and detail of funding/support)**

ii) does the source of the funding present any conflict of interest with regard to the research topic?

iii) identify any potential conflict of interest due to the source of funding and explain how this will be managed?

58	**Does the researcher/s have a financial interest in the outcome of the project?**	**Yes**		**No**	✓

If yes, explain how the conflict of interest situation will be dealt with.

59 Describe any professional or other relationship between the researcher and the participants? (e.g. employer, employee, work colleague, lecturer/student, practitioner/patient, researcher/family member). Indicate how any resulting conflict of role will be dealt with.

None is anticipated; however any potential relationships will be discussed initially with the researcher's supervisors. Potential participants will have had the opportunity to self-select, it can be assumed a participant would not proceed if not comfortable.

The student researcher will exclude participants with whom they have an established relationship.

SECTION H: COMPENSATION TO PARTICIPANTS (Refer Code Section 4, Para 23)

60	**Will any payments, koha or other form of compensation or acknowledgement be given to participants?**	**Yes**	✓	**No**	

If yes, describe what, how and why.

(Note that compensation (if provided) should be given to all participants and not constitute an inducement. Details of any compensation provided must be included in the Information Sheet.)

Participants will be given a small koha, such as a petrol voucher or movie ticket, to thank them for giving up their time to participate.

This will be given following completion of the interview and will be unknown to the participants, so will not constitute an inducement to participate in the research.

SECTION I: TREATY OF WAITANGI (Refer Code Section 2)

61 **Are Maori the primary focus of the project?** **Yes** [ ] **No** [✓]

If yes: Answer Q62 – 65

If no, outline:i) what Maori involvement there may be, and

A Māori RSW may offer to participate in this research.

ii) how this will be managed.

As a social worker, the researcher's practice is informed by bi-cultural competent practice framework. This means the researcher has a general knowledge of basic tikanga and kawa to ensure a culturally respectful space is provided in which to conduct the research.

62 **Is the researcher competent in te reo Maori and tikanga Maori?** **Yes** [ ] **No** [ ]

If no, outline the processes in place for the provision of cultural advice.

63 **Identify the group/s with whom consultation has taken place or is planned and describe the consultation process.**

(Where consultation has already taken place, attach a copy of the supporting documentation to the application form, e.g. a letter from an iwi authority)

64 **Describe any ongoing involvement of the group/s consulted in the project.**

65 **Describe how information resulting from the project will be shared with the group/s consulted?**

SECTION J: CULTURAL ISSUES (Refer Code Section 3, Para 15)

66 **What ethnic or social group/s (other than Maori) does the project involve?**

The project involves discussion around two cultural groups that of AOs and alcohol users. Participants will all be RSWs who can undertake an interview in English.

67 **Are there any aspects of the project that might raise specific cultural issues?** **Yes** ☐ **No** ☑

If yes, explain. Otherwise, proceed to Section K.

68 **Does the researcher speak the language of the target population?** **Yes** ☑ **No** ☐

If no, specify how communication with participants will be managed.

69 **Describe the cultural competence of the researcher for carrying out the project.**

(Note that where the researcher is not a member of the cultural group being researched, a cultural advisor may be necessary)

70 **Identify the group/s with whom consultation has taken place or is planned.**

(Where consultation has already taken place, attach a copy of the supporting documentation to the application form)

71 **Describe any ongoing involvement of the group/s consulted in the project.**

72 **Describe how information resulting from the project will be shared with the group/s consulted.**

73 **If the research is to be conducted overseas, describe the arrangements you will make for local participants to express concerns regarding the research.**

N/A

SECTION K: SHARING RESEARCH FINDINGS (Refer Code Section 4, Para 26)

74 **Describe how information resulting from the project will be shared with participants and disseminated in other forums, e.g. peer review, publications, and conferences.**

(Note that receipt of a summary is one of the participant rights)

Participants will be provided with a summary of the research once it has been finalised. Abstracts may be submitted to journals for future publication following the finalisation of the thesis.

SWRB will be provided a copy of completed thesis.

SECTION L: INVASIVE PROCEDURES/PHYSIOLOGICAL TESTS (Refer Code Section 4, Para 21)

75 **Does the project involve the collection of tissue, blood, other body fluids; physiological tests or the use of hazardous substances, procedures or equipment?** **Yes** [ ] **No** [✓]

If yes, are the procedures to be used governed by Standard Operating Procedure(s)? If so, please name the SOP(s). If not, identify the procedure(s) and describe how you will minimise the risks associated with the procedure(s)?

76 **Does the project involve the use of radiation (x-ray, CT scan or bone densitometry (DEXA))?** **Yes** [ ] **No** [✓]

If yes, has the Massey Licensee been contacted and consulted? **Yes** [ ] **No** [ ]

(A copy of the supporting documentation must be provided with the ethics application, i.e. relevant SOP, participant dose assessment calculation sheet and approval of the dose assessment from the relevant authority). NOTE: See "Additional Information for Researchers" (Item 4.2) document for further detail.

(If yes to Q75 and/or Q76, complete Section L; otherwise proceed to Section M)

77 **Describe the material to be taken and the method used to obtain it. Include information about the training of those taking the samples and the safety of all persons involved. If blood is taken, specify the volume and number of collections.**

78 **Will the material be stored?** **Yes** [ ] **No** [ ]

If yes, describe how, where and for how long.

79 **Describe how the material will be disposed of (either after the research is completed or at the end of the storage period).**

(Note that the wishes of relevant cultural groups must be taken into account)

80 **Will material collected for another purpose (e.g. diagnostic use) be used?** **Yes** [ ] **No** [ ]

Yes [ ] **No** [ ]

If yes, did the donors give permission for use of their samples in this project?
(Attach evidence of this to the application form).

If no, describe how consent will be obtained. Where the samples have been anonymised and consent cannot be obtained, provide justification for the use of these samples.

81 **Will any samples be imported into New Zealand?** **Yes** ☐ **No** ☐

If yes, provide evidence of permission of the donors for their material to be used in this research.

82 **Will any samples go out of New Zealand?** **Yes** ☐ **No** ☐

If yes, state where.

(Note this information must be included in the Information Sheet)

83 **Describe any physiological tests/procedures that will be used.**

84 **Will participants be given a health-screening test prior to participation?** *(If yes, attach a copy of the health checklist)* **Yes** ☐ **No** ☐

Reminder: Attach the completed Screening Questionnaire and other attachments listed in Q5

SECTION M: DECLARATION (*Complete appropriate box)*

ACADEMIC STAFF RESEARCH

Declaration for Academic Staff Applicant

I have read the Code of Ethical Conduct for Research, Teaching and Evaluations involving Human Participants. I understand my obligations and the rights of the participants. I agree to undertake the research as set out in the Code of Ethical Conduct for Research, Teaching and Evaluations involving Human Participants. My Head of Department/School/Institute knows that I am undertaking this research. The information contained in this application is to the very best of my knowledge accurate and not misleading.

Staff Applicant's Signature ..... Date: .....

STUDENT RESEARCH

Declaration for Student Applicant

I have read the Code of Ethical Conduct for Research, Teaching and Evaluations involving Human Participants and discussed the ethical analysis with my Supervisor. I understand my obligations and the rights of the participants. I agree to undertake the research as set out in the Code of Ethical Conduct for Research, Teaching and Evaluations involving Human Participants.

The information contained in this application is to the very best of my knowledge accurate and not misleading.

Student Applicant's Signature ..... Date: .....

Declaration for Supervisor

I have assisted the student in the ethical analysis of this project. As supervisor of this research I will ensure that the research is carried out according to the Code of Ethical Conduct for Research, Teaching and Evaluations involving Human Participants.

Supervisor's Signature ..... Date: .....

Print Name .....

GENERAL STAFF RESEARCH/EVALUATIONS

Declaration for General Staff Applicant

I have read the Code of Ethical Conduct for Research, Teaching and Evaluations involving Human Participants and discussed the ethical analysis with my Line Manager. I understand my obligations and the rights of the participants. I agree to undertake the research as set out in the Code of Ethical Conduct for Research, Teaching and Evaluations involving Human Participants. The information contained in this application is to the very best of my knowledge accurate and not misleading.

General Staff Applicant's Signature ..... Date: .....

Declaration for Line Manager

I declare that to the best of my knowledge, this application complies with the Code of Ethical Conduct for Research, Teaching and Evaluations involving Human Participants and that I have approved its content and agreed that it can be submitted.

Line Manager's Signature ..... Date: .....

Print Name .....

TEACHING PROGRAMME

Declaration for Paper Controller

I have read the Code of Ethical Conduct for Research, Teaching and Evaluations involving Human Participants. I understand my obligations and the rights of the participants. I agree to undertake the teaching programme as set out in the Code of Ethical Conduct for Research, Teaching and Evaluations involving Human Participants. My Head of Department/School/Institute knows that I am

undertaking this teaching programme. The information contained in this application is to the very best of my knowledge accurate and not misleading.

Paper Controller's Signature ..... Date: .....

Declaration for Head of Department/School/Institute

I declare that to the best of my knowledge, this application complies with the Code of Ethical Conduct for Research, Teaching and Evaluations involving Human Participants and that I have approved its content and agreed that it can be submitted.

Head of Dept/School/Inst Signature ..... Date: .....

Print Name .....

References:

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Appendix A- Screening Questionnaire to Determine the Approval Procedure

Te Kunenga ki Pürehuroa

SCREENING QUESTIONNAIRE

TO DETERMINE THE APPROVAL PROCEDURE

(Part A and Part B of this questionnaire must both be completed)

Name: Lee Henley

Project Title: Older adults and alcohol: A study of registered social workers assessment practices

This questionnaire should be completed following, or as part of, the discussion of ethical issues.

Part A

The statements below are being used to determine the risk of your project causing physical or psychological harm to participants and whether the nature of the harm is minimal and no more than is normally encountered in daily life. The degree of risk will then be used to determine the appropriate approval procedure.

If you are in any doubt you are encouraged to submit an application to one of the University's ethics committees.

Does your Project involve any of the following?

(Please answer all questions. Please circle either YES or NO for each question)

Risk of Harm

1.	Situations in which the researcher may be at risk of harm.	NO
2	Use of questionnaire or interview, whether or not it is anonymous which might reasonably be expected to cause discomfort, embarrassment, or psychological or spiritual harm to the participants.	NO
3.	Processes that are potentially disadvantageous to a person or group, such as the collection of information which may expose the person/group to discrimination.	NO
4.	Collection of information of illegal behaviour(s) gained during the research which could place the participants at risk of criminal or civil liability or be damaging to their financial standing, employability, professional or personal relationships.	NO
5.	Collection of blood, body fluid, tissue samples, or other samples.	NO
6.	Any form of exercise regime, physical examination, deprivation (e.g. sleep, dietary).	NO
7.	The administration of any form of drug, medicine (other than in the course of standard medical procedure), placebo.	NO
8.	Physical pain, beyond mild discomfort.	NO
9.	Any Massey University teaching which involves the participation of Massey University students for the demonstration of procedures or phenomena which have a potential for harm.	NO

Informed and Voluntary Consent

10. Participants whose identity is known to the researcher giving oral consent rather than written consent (if participants are anonymous you may answer No).	NO
11. Participants who are unable to give informed consent.	NO
12. Research on your own students/pupils.	NO
13. The participation of children (seven (7) years old or younger).	NO
14. The participation of children under sixteen (16) years old where active parental consent is not being sought.	NO
15. Participants who are in a dependent situation, such as those who are under custodial care, or residents of a hospital, nursing home or prison or patients highly dependent on medical care.	NO
16. Participants who are vulnerable.	NO
17. The use of previously collected identifiable personal information or research data for which there was no explicit consent for this research.	NO
18. The use of previously collected biological samples for which there was no explicit consent for this research.	NO

Privacy/Confidentiality Issue

19. Any evaluation of organisational services or practices where information of a personal nature may be collected and where participants or the organisation may be identified.	NO

Deception

20. Deception of the participants, including concealment and covert observations.	NO

Conflict of Interest

21. Conflict of interest situation for the researcher (e.g. is the researcher also the lecturer/teacher/treatment-provider/colleague or employer of the research participants or is there any other power relationship between the researcher and research participants?)	NO

Compensation to Participants

22. Payments or other financial inducements (other than reasonable reimbursement of travel expenses or time) to participants.	NO

Procedural

23. A requirement by an outside organisation (e.g. a funding organisation or a journal in which you wish to publish) for Massey University Human Ethics Committee approval.	NO

Part B

FOR PROPOSED HEALTH AND DISABILITY RESEARCH ONLY

Not all health and disability research requires review by a Health and Disability Ethics Committee (HDEC).

Your study is likely to require HDEC review if it involves:

- **human participants recruited in their capacity as:**
  - **consumers of health or disability support services; or**
  - **relatives or caregivers of such consumers; or**
  - **volunteers in clinical trials; or**
- **human tissue; or**
- **health information.**

In order to establish whether or not HDEC review is required: (i) read the Massey University Digest of the HDEC Scope of Review standard operating procedure; (ii) work through the 'Does your study require HDEC review?' flowchart; and (iii) answer Question 24 below.

If you are still unsure whether your project requires HDEC approval, please email the Ministry of Health for advice (hdecs@moh.govt.nz) and keep a copy of the response for your records.

24. Is HDEC review required for this study?	NO

In discussion with supervisors a decision to make a full ethics application was thought beneficial.

Appendix 3: Letter to SWRB

Jan Duke,

Social Workers Registration Board

Level 6

11 Chews Lane

Wellington

6011

6/3/15

Dear Jan,

I am a current Master of Social Work student at Massey University. I am undertaking a small scale research project as part fulfilment of my degree.

I will be focusing my thesis on the views and perceptions of Registered Social Workers regarding Older Adults and alcohol use/misuse. This is an emerging Health concern that has not been explored in terms of social work within New Zealand. I hope to explore whether Registered Social Workers ask Older Adults about alcohol, what training has been provided regarding this issue, what assessment tools are utilised within Health agencies and how socially constructed perceptions of the subject may impact practice.

I am approaching the SWRB as the only agency that holds a comprehensive list of Registered Social Workers in New Zealand. This initial contact is to request your help in passing on details of my research to Registered Social Workers who work within the Great Wellington region. Registered Social Workers will then have the option to self-select interest in becoming a participant by contacting me directly.

I hope to speak with 6-8 Registered Social Workers to undertake in-depth interviews of their views of whether Older Adults are asked about alcohol use during assessment processes, provided they meet the following criteria.

- live in the Greater Wellington Region
- be able to participate in a face-to-face interview conducted in English
- be a Registered Social Worker with SWRB

- and assessed the needs of an Older Adult (participants to self-select this criteria)

I would appreciate an indication of whether you would be happy to pass on the details of my research to Registered Social Workers. If you are happy to do so I will send you an information sheet for potential participants, indicating how they can make contact with me directly.

I will provide the SWRB with a completed copy of the findings of this research.

If you have any questions you can contact me at:

[redacted]

Ph: [redacted]

Alternatively you can contact one of my supervisors:

Associate Professor Kieran O'Donoghue or Dr Michael Dale

[redacted]

[redacted]

Thank you for your assistance

Regards,

Lee Henley

Appendix 4: Letter to Registered Social Workers

To: Registered Social Workers

From: Social Workers Registration Board

Regarding: Opportunity to participant in research around older adults and alcohol use / misuse

Dear Registered Social Worker,

Another SWRB registered social worker, Lee Henley, is undertaking his Masters in Social Work at Massey University and undertaking research in regard to:

Older adults and alcohol: A study of registered social workers assessment practices

This email is to invite you to be a participant in this research, you do not need to be currently be working with older adults, but you do need to have assessed an older adult at some point in your social work career.

The attached participant information sheet provides required details for you to self-select interest in this piece of work, details and background about Lee and what to do next if you wish to be a participant.

Appendix 5: Information Sheet

Older adults and alcohol: A study of registered social workers' assessment practices

INFORMATION SHEET

Dear Registered Social Worker,

My name is Lee Henley, like you I am a New Zealand Registered Social Worker. I have worked in a range of social work settings over a 25 year period. These settings have included health, mental health / addictions, child protection and disability. One of my interests is working with Older Adults and the largely unrecognised area of alcohol use / misuse. Currently I am a Master of Social Work student at Massey University undertaking a small scale research study as part of the requirements for this degree.

Project Description and Invitation

I will be exploring registered social worker's views on Older Adults and alcohol use / misuse and the assessment tools that help us undertake assessments in this area. I would like to invite you to become part of this research. To participate you must be currently registered with the Social Workers Registration Board, live in the Greater Wellington Region and be able to participate in a face to face interview conducted in English. In addition you need to have assessed an Older Adult's needs. There are no restrictions on time practicing or current place of employment.

Older Adults and alcohol use / misuse is an emerging Health concern that has not been explored in terms of social work within New Zealand. I hope to explore whether Registered Social Workers ask Older Adults about alcohol, what training has been provided regarding this issue, what assessment tools are utilised within Health agencies and how socially constructed perceptions of the subject may impact practice.

Participation in this research is voluntary. Details of all participants who self-select to contribute will remain confidential. This is the first attempt to explore New Zealand Registered Social Worker's perceptions of this emerging health concern. Findings will help to address a lack of local social work knowledge in this area and may contribute to improvements in practice.

Project Procedures

Participants will be accepted on a first come first served basis assuming they fit the above criteria. I will travel to meet you at a mutually agreed time and place. It is expected that the interview will take between 75-90 minutes and with your permission will be audibly recorded. You will be able to review the transcript approximately one month following the interview and correct any inaccuracies.

Anyone who participates in this research will have the right to:

- withdraw from the study (up until the approval of the transcripts)
- decline to answer any particular question
- ask any questions about the study at any time
- request the recorder be turned off at any time during the interview
- provide information on the understanding that your name nor the name of the agency you are connected with, will not be used
- be given access to a summary of the project findings when it is concluded, and
- bring a support person with you to the interview, if you chose.

Data Management

The data collected for this research will be used for the purposes of this study and any subsequent papers written as a result. All transcripts will be kept in password protected files and deleted after use.

Project Contacts

If you want to participate, or have further questions, please contact me at:

Lee Henley:

[redacted]

[redacted]

Alternatively you can contact one of my supervisors:

Associate Professor Kieran O'Donoghue or Dr Michael Dale

[redacted]

[redacted]

Committee Approval Statement

This project has been reviewed and approved by the Massey University Human Ethics Committee: Southern A, Application _15/28__. If you have any concerns about the conduct of this research, please contact Mr Jeremy Hubbard, Acting Chair, Massey University Human Ethics Committee: Southern A, telephone 04 801 5799 x 63487, email humanethicsoutha@massey.ac.nz.

Appendix 6: Consent Form

Older adults and alcohol: A study of registered social workers' assessment practices

PARTICIPANT CONSENT FORM - INDIVIDUAL

I have read the Information Sheet and have had the details of the study explained to me. My questions have been answered to my satisfaction, and I understand that I may ask further questions at any time.

I agree/do not agree to the interview being sound recorded.

I wish/do not wish to have my recordings returned to me.

I agree to participate in this study under the conditions set out in the Information Sheet.

Signature: **Date:**

Name printed: .....

Appendix 7: Questions for semi-structured interviews

Introduction:

Brief introduction to self and research topic

Go through consent form, answer any questions and gain written consent.

How long have you been a RSW?

How long have you been in your current role?

How much experience have you had in assessing Older Adults (OAs)?

What did your most recent experiences in assessing OAs comprise of?

How did you undertake the assessment?

How much experience have you had working with people who use alcohol?

What did you most recent experience of working with people who use alcohol involve?

How did you approach the assessment of alcohol use?

What experiences have you had in assessing alcohol use amongst OAs?

Can you outline an example of how you did this?

What processes or assessment tools does your organisation use when assessing OAs?

How does the assessment tool facilitate questions around alcohol use?

What training did you receive to use the assessment tool?

If there is no recommended tool in place how do you select questions to ask?

How do you approach the subject of alcohol use?

In what ways could assessment tools for this cohort of people be improved?

What tools are you aware of that are designed to assess alcohol use with OAs?

What is your understanding of OAs and alcohol use?

What is your understanding of why OAs use alcohol?

In what ways do OAs have different risk factors regarding alcohol use compared to younger users?

What is your understanding of recommended levels of alcohol use for an OA?

Have you received any training in the area of OAs and alcohol use?

What influences your perception of OAs and alcohol use?

What is your experience of OAs and alcohol?

What do you consider to be the difference between use and misuse in OAs?

Should OAs be asked about alcohol use?

What perceptions do you have regarding OAs and alcohol use and where do these perceptions originate from?

Do you believe some OAs use/misuse alcohol? Please expand.

Do you discuss OAs and alcohol with colleagues?

What needs to be in place regarding Older Adults and alcohol use?

What local services are in place to meet the needs of OAs using alcohol?

What needs to be in place for OAs regarding alcohol use?

General comments

Are there any other comments you would like to make?

Conclusion

Thank the RSW for their time

Explain what will happen next

Explain how the results will be disseminated to them

Appendix 8: Release Form

AUTHORITY FOR THE RELEASE OF TRANSCRIPTS

I confirm that I have had the opportunity to read and amend the transcript of the interview(s) conducted with me.

I agree that the edited transcript and extracts from this may be used in reports and publications arising from the research.

Signature: ..... **Date:** .....

Full name : .....