Cross Cutting themes

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INTRODUCTION to SUMMARY and DISCLAIMERS

- Hard to separate self from presentations (so a lot of self-referencing here!)
- Diverse audience – very useful dialogue … but hard to actually 'come together' within systems that seem to remain and to some extent increase in separation (Silos)
- Awareness raising – re issue and information – excellent content and a lot of new knowledge for all of us.

WHAT IS OLD AGE?

Relative but bear in mind:

- Large age range (in itself)
- Capacity and developmental stage – different to chronology
- Different cohorts (with drugs and also prescribed medications sourced legally and illicitly).
- Living longer – various reasons ….. but what about generational change in this too ? “our children will not live as long as we will”
- Differences for different sub-groups (ATSI, women/men, co-occurring conditions, inequality gap, …)
- ….

CULTURAL EXPECTATIONS OF OLDER YEARS

- What happened to our parents?
- Cohort expectations of rights and responsibilities
- Incentives for living (or not)
- What we 'should grin and bear', what constitutes a problem (including health problem),
- What extended life can I purchase? (Life as a commodity)
- Expectations of health care personnel – worth it / time to do it / what's critical and important in presentation cf. what preventive care necessary / relief of symptoms / capacity to assess polypharmacy in systems that are increasingly siloed (and reluctance to meddle with meds prescribed by another specialist prescriber including GP's).
- Sleep – how much is 'needed' / 'normal'?
- Magic bullet for ailments / 'ab-normality'
- Approahces to end of life including decisions along the way – palliation (and capacity of the patient to influence).

CHANGES IN OLDER YEARS

ROLES:

- Obvious …. (already covered)
- But also – some take on care of grandchildren, carers or their children & sometimes have taken on care and legal responsibility for grandchildren;

BODIES:

- Physiology including brain – covered. And complex (including, for eg: weight loss in older people)
- Information (eg: How much exercise do I need to maintain / retain muscle mass; which muscles should I concentrate on re ongoing quality of life; who are the experts re this?)

RESPONSES TO MEDICATIONS

- Ageing complicates medication action …. (and vice versa)
- Eg: Possible that methadone not the best substitute opiate in older years re cognitive capacity ?Suboxone better

WHOSE PERSPECTIVE DO WE VIEW OLDER YEARS AND DRUG USE THROUGH? AND WHAT'S OUR RESPONSE? Is there a correct response? (Not easy and not uniform)

- Person/patient ….
- Significant others especially Family members
- Clinicians (Medical / Other health professionals / specialists / generalists / … social and relationship professionals).
- Society (costs / cultural and religious expectations / … …other

NOTE: Many mentions of costs in presentations.

- Eg: Note the costs to health care including opportunity costs re other patients …. Not paid … beyond acute episode or paid for only about 4 days.
- Note: Prisons and corrections populations – ditto.

WHICH DRUGS ……

- WHY AND HOW WE MIGHT EXPECT SHIFT OVER TIME …. IMPACT AND HOW INTERACT NA DHOW PRESENT IN OLDER YEARS ….
  - Alcohol
  - BZT’s
  - Opiates
  - Cannabis
  - Others ……

REMINDERS:

- Research base not complete (in fact sparse)
- Information, education and training (Professionals, carers and patients/clients/CONSUMERS /SERVICE USERS and also for the general public) still vitally needed re expectations (eg: Medications and pros and cons; engagement with balancing benefits/potential harms; sleep patterns, etc).
- Screening and assessment - need to explore which are appropriate for older people
  - FOLLOW THROUGH WITH ACTION to responses
  - NK: GGT. testing might be useful screen test in older (not younger) people.
- Treatment of older people with AOD 'misuse' should be planned and carried out in an integrated service system (hmmm…)
- Risky drinking of alcohol – short and longer term different but both significant.
- Cultural place of alcohol remains problematic – overall … with older people taking younger drinking patterns in to older years. (SW)

REMINDERS (CONT.):

- Many of our clients/service users are ageing and their needs are changing (eg: OST for behavioural change / physical change?)
- Mental health parallels and co-occurring disorders need to remain a focus (including Veterans)
- Prescription of opiates is not necessarily problematic (treatment of pain) – NB Issue of access to pain relief internationally.
- Physical assessments – critical in middle and further years, Often 'neglected' in AOD services; need well connected and integrated services.
- Documentation – need more eg: Falls data – collect involvement of alcohol and/or other drugs (and med's). Note: Long history of trying to get this in many spheres such as Gen Med Practice, AD Dept.s policing and other areas).

Ending thoughts:

BALANCE (NDS) – REDUCTNG HARMS of DRUGS

- Who defines the harm- need to reflect on sort in minimising harms of interventions.
- Preventing and reducing harm : Prevention - building resilience and reducing harm …. as we age
- Reminder of early career experiences: Teaching med residents :
  - Alcohol safe levels < 10 drinks a day (Men and women)
  - Family members – the job of the SW/Psych.
  - How access people earlier in their dependence trajectory – prevent extreme harms?
  - What about the kids of these patients?
- My past 24 hours: Last night went to the 18th Birthday of the YSAS in Melb. And recall ….
- ….. My paper speech in about 1972 at the (then) St Vincent's (Melb) Summer School on Alcohol Studies (on locating & building capacity of young people & providing support and responses to young people affected by drugs); I made a wry comment that one day we might need to think about specific and special needs for AOD services for the aged; maybe in my life time. (Greying time!)
- Maybe … some of you will still be hanging in there when we see some recognition and resourcing of services that focus especially on older Australians where AOD is an issue.
- BUT at the end of the day we must all play our part and recall that humans are distinguished by our capacity to be humane.

ENDINGS

- HUMAN RESPONDING
- Maybe this the most shared aspect of both AOD and AGED care sector
- (Stephen – welcome to country) reminder re older years for aboriginal people(s) young.
- Stimulate older people – encourage, keep active, keep going ….. include/engage & support
- (especially hard when they have a history of complex problems and isolation from families,
- Need to > ambulatory care to facilitate this care of older people with AOD complexities – not going to 'fit' readily in to current service system.