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Australia's National Research Centre on AOD Workforce Development

FIFTY SHADES OF GREY: ALCOHOL AND OTHER DRUG PROBLEMS AMONG OLDER AUSTRALIANS – BARRIERS TO TREATMENT

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Older people and AOD harm

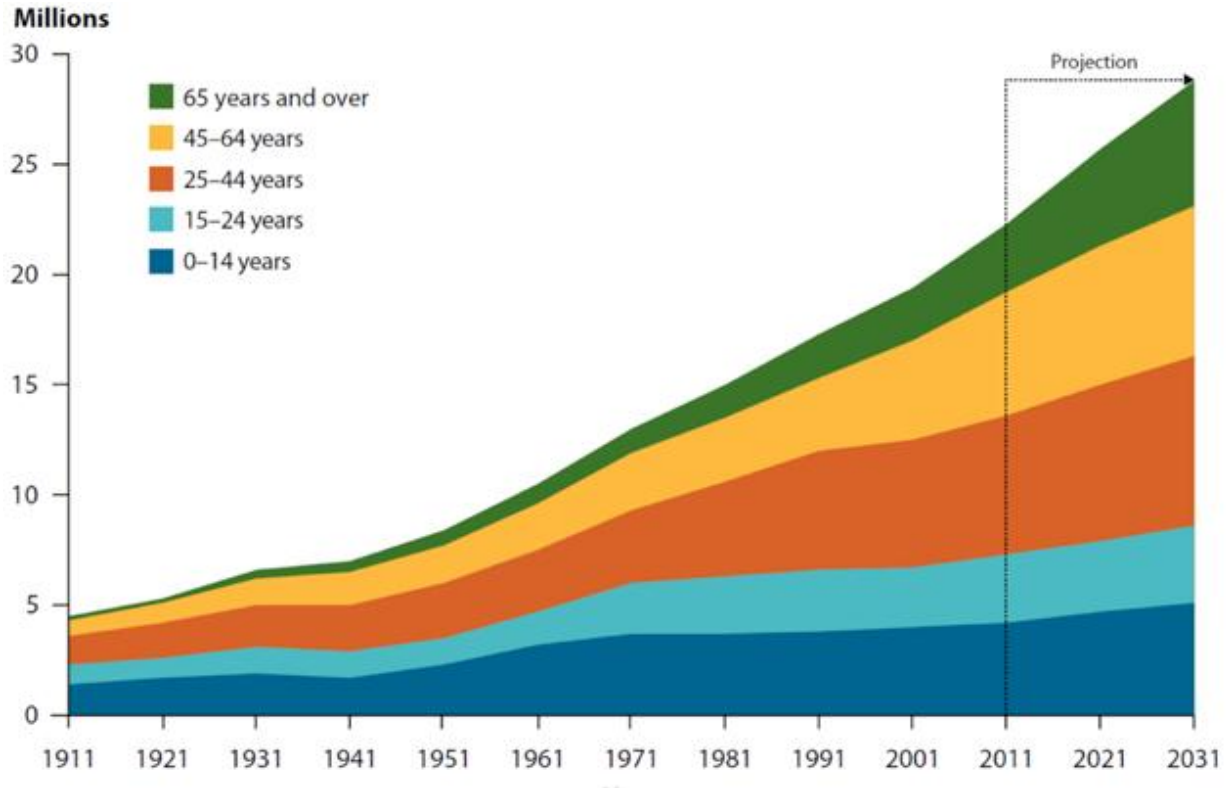
* > 55 years
* Results of a literature review concerning older people and access to AOD prevention and intervention services
* Prevention and intervention are just as important for older people
* Older people with substance misuse problems are not a homogenous group
* Most are unlikely to need specialist services
* Primary care providers, mental health services, social care providers and residential services are pivotal in prevention / interventions

Older people and AOD harm

* Older people do just as well in AOD interventions as their younger counterparts
* Older people with extensive AOD harm in residential care facilities

What's the issue?

Australia's population is ageing and is doing so at a faster rate than ever before (Australia to 2050: Future challenges, 2010).



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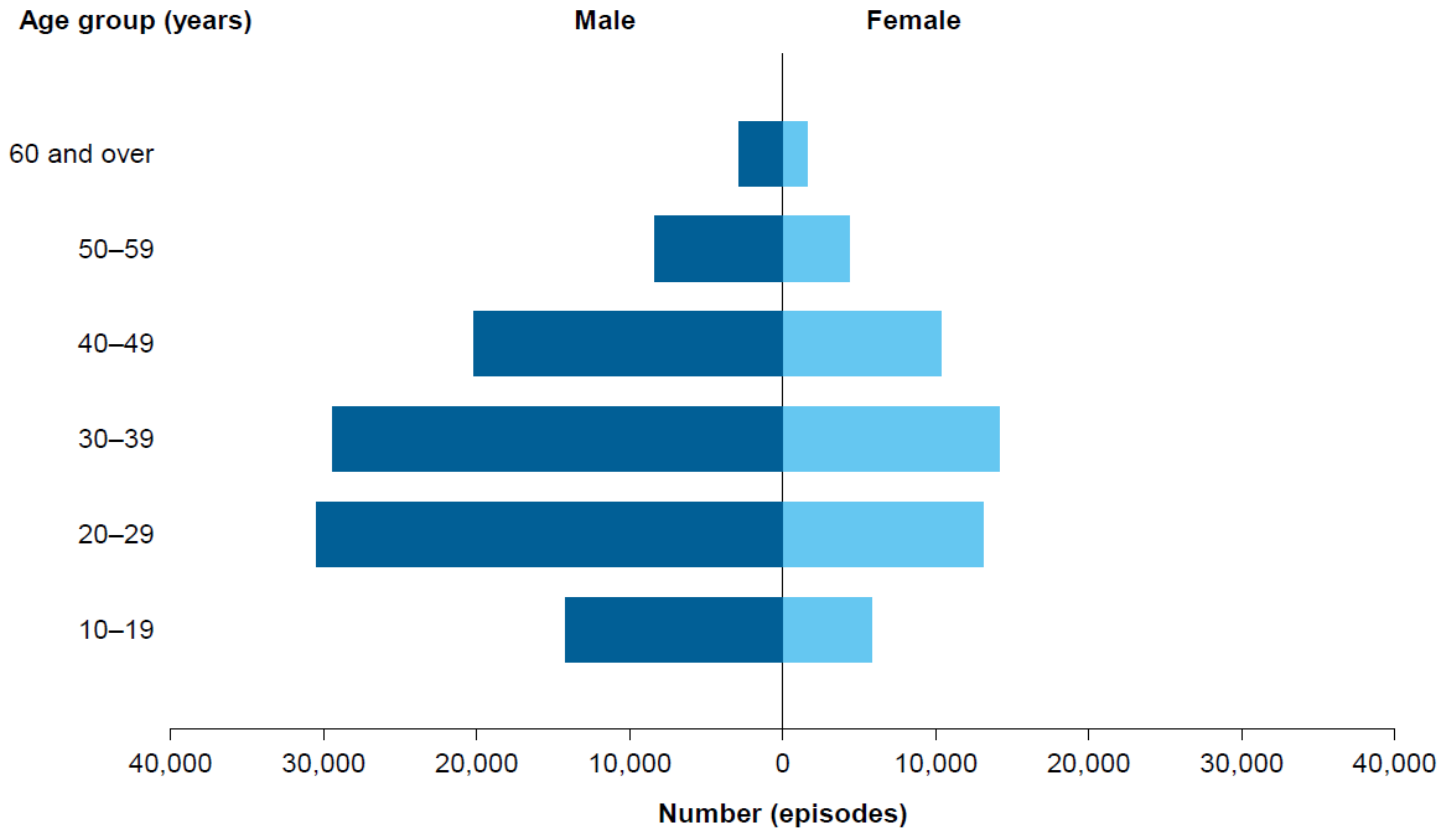
What's the issue?

* Dramatic future increase in the absolute number of older individuals with AOD problems
* Baby boomers used AOD at higher rates than previous generations and many still do
* Ageing-related reduction in capacity to metabolise AOD (i.e., same intake, more harm)
* Increased disposable income can increase consumption and corresponding problems
* Advances in health care services → living longer and healthier ↑ exposure harmful AOD use ↓ incentive to change until problems become too severe.

What's the issue?

* Increased use of other medicines with AOD
* Increased prevalence of co-morbidities
* New patterns of problems (e.g., combination alcohol and prescription drug use, longer-term OST clients)
* Living longer → stressors (e.g. bereavement or social isolation)
* Baby boomers views, values and expectations of a 'quick-fix' and the impact on use of medications
* ↑ population use of medicines (e.g. opioids and sedative / hypnotics) spills over into problem use

What's the issue?



Closed treatment episodes provided for own drug use, by age group and sex, 2012–13

Source: AIHW (2014)

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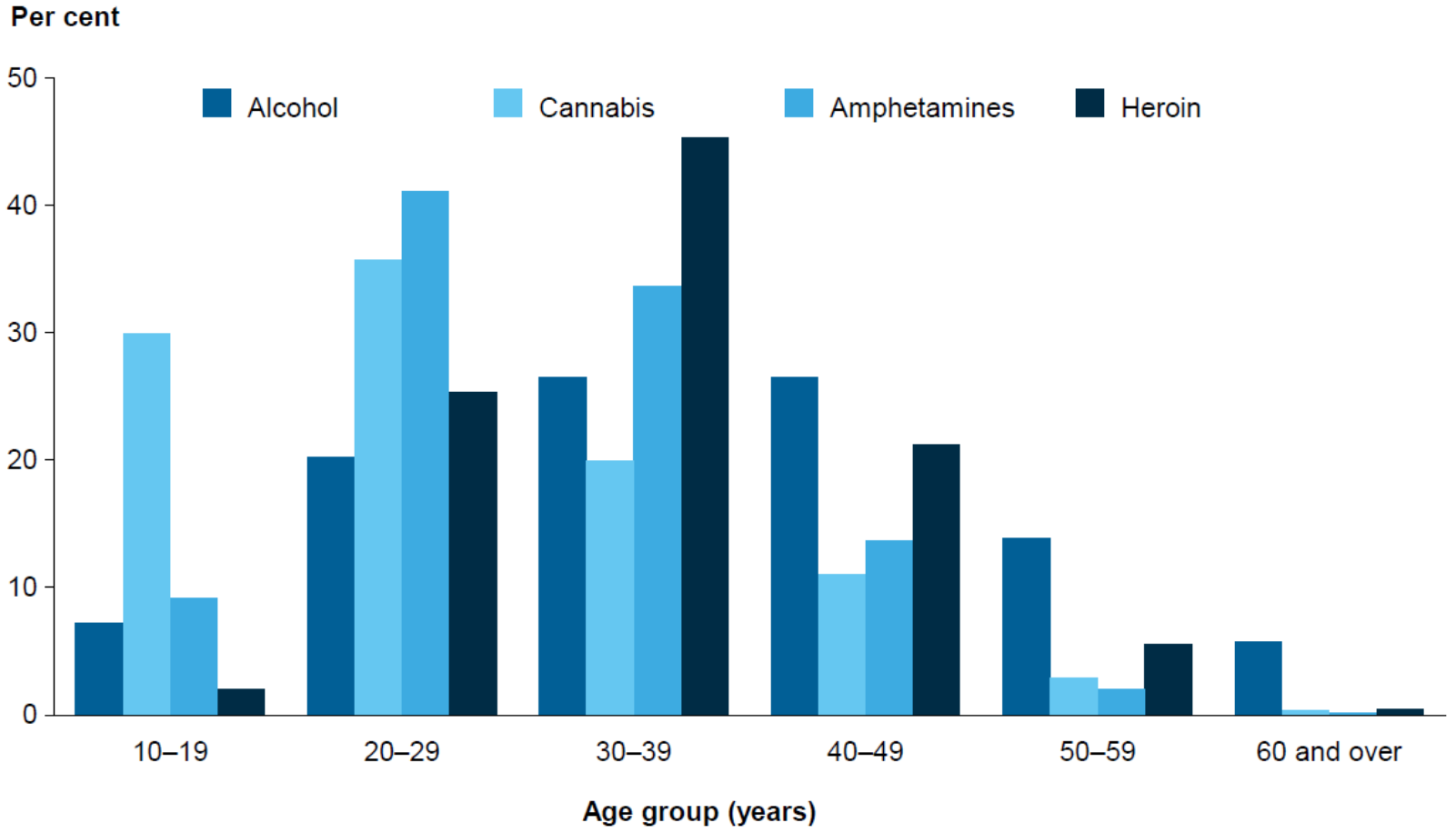
What's the issue?

* Between 2003-04 and 2012-13 the proportion of AOD treatment episodes for **50-59 year olds** increased from **5.7% - 8.19%**
* Between 2003-04 and 2012-13 the proportion of AOD treatment episodes for **>60 year olds** increased from **1.9% - 2.9%** (AIHW, [2004] , AIHW, [2014])
* Between **2006–2013** the proportion of OST clients aged <30 more than halved (from 28% to 11%), those aged >50 and over more than doubled (from 8% to 19%) (AIHW, 2014).

What's the issue?



Closed treatment episodes provided for own drug use, by selected principal drugs of concern and age group, 2012–13

Source: AIHW (2014)

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Three groups of older people

* ***Maintainers:*** Have continued their previously unproblematic use into older age but age-related changes (metabolic, co-morbidities, other medicines) result in increased harms later in life
* ***Survivors:*** Early onset users who have a long history of substance use problems which persist into older age and often have resultant co-morbidities
* ***Reactors:*** Late onset users whose problem use begins in their 50s or 60s and is often associated with stressful events (e.g., bereavement, retirement, marital breakdown or social isolation) (Gossop, 2008)

Four types of barriers

* Lack of screening
* Individual characteristics
* Issues related to health and welfare professionals
* Practical issues.

Lack of screening

- Prevention and screening may not be seen as relevant to older people
- Many broader population screening approaches are:
  - not age-specific
  - not sufficiently sensitive to older peoples' biological and social characteristics
  - insufficiently sensitive to detect less severe problems and facilitate early/brief intervention
  - don't take account of concomitant use of other medicines
- Australian Alcohol-Related Problems Survey (A-ARPS) screens for alcohol, not other drug problems

Individual characteristics

* Reluctant or embarrassed to ask for help
* May not want to re-engage with services as a result of perceptions that they have 'failed'
* Believing it is too late to change
* Relying on self-diagnosis / attributing symptoms to the ageing process
* Cognitive problems, such as substance-induced memory loss or underlying dementia
* Unwillingness to disclose problems
* Collusion of family members
* A desire to continue using

Barriers related to health / welfare professionals

* Ageism, negative stereotypes and attributing problems to the ageing process rather than substance use
* A lack of awareness / inability to identify signs and symptoms of substance use problems among older people
* A reluctance to ask embarrassing or sensitive questions of older people
* Believing older people are too old to change their behaviour
* Believing that it is wrong to 'deprive' older people of their 'last pleasure in life'

Practical Barriers

* Transport, mobility, language or hearing difficulties specially those who are frail, homebound or in rural or poorer urban communities
* Social isolation can result in serious problems going undetected
* Not knowing where to turn for help
* Time constraints: Caring for a spouse, relative, friend or grandchildren
* Mixed-age clinical services may be uncomfortable or unwelcoming - younger clients may be 'hectic', 'chaotic', or intimidating (Wadd et al., 2011)

Enabling factors

* Having options: One-to-one support, counselling and group work
* Group work can also help address loneliness and isolation, common underlying causes of substance use problems among older people
* Age-specific, supportive, non-confrontational services which have a culture of respect and aim to build self-esteem
* Addressing depression, loneliness, and loss (e.g., death of a spouse, retirement) and rebuilding social support networks
* Being flexible and conducted at an appropriate pace

Enabling factors

* Involve families and carers as appropriate
* Involve staff members who are interested and experienced in working with older adults
* Use case management and create linkages with medical, ageing and referral services (particularly in relation to co-morbidities)
* Take a broad, holistic approach to treatment incorporating age-specific psychological, social and health problems

In conclusion:

Providing appropriate AOD prevention and treatment services will play an increasingly important role in the healthy ageing of Australians.

To do so requires identifying and responding to factors which enable or act as barriers to older people accessing these services.

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