Alcohol service provision for older people in an area in North East England which experiences high levels of alcohol use and health inequalities

Introduction

Older people who drink alcohol, drink more than their counterparts from previous generations, drink more frequently than all other age groups and are more likely to drink at home and alone (Wadd, Lapworth, Sullivan et al 2011). In England, 28% of men and 14% of women over 65 drink alcohol more than 5 times a week (Wilson, Kaner, Crosland, Ling, McCabe & Haighton 2013), a significant number drink at levels dangerous to health (Royal College of Psychiatrists [RCP] 2011).

Alcohol problems in later life are often less obvious, under-detected and under-reported (Anderson, Scafato, & Galluzzo 2012). Older people can experience complex and multiple risk factors (Wadd et al, 2011) and often alcohol-related issues are complicated by other physical and/or psychological issues (RCP, 2011).

Stigma, embarrassment and societal stereotypes of 'older people' and 'alcohol users' exacerbate underreporting and help-seeking (Wadd et al 2011). Older drinkers often perceive it is too late to seek help or that services prioritise younger drinkers or users of other drugs (Wilson et al 2013). Many older people are unaware of existing services and how to access these (Lock et al 2010). Clinicians too lack confidence raising the issue, fearing they will offend (Lock, Kaner, Lamont et al, 2002). Non-recognition of alcohol problems however can lead to misdiagnoses and lack of appropriate support (RCP, 2011).

This study sought to identify specific alcohol services for older people and explore the extent to which generic services and drug and alcohol services tailor provision to meet the needs of older clients.

Method

Aim

The aim of this mapping study was to identify existing alcohol services within South of Tyne, North East England (South Tyneside, Gateshead, Sunderland) to capture the extent of service provision for older people and identify any gaps.

Context

North East England has a high proportion of people (48% men/29% women) reporting drinking above UK recommended limits and the highest rate of alcohol-related deaths in England (Balance

North East, 2014). In 2006, mortality rates in South of Tyne were 8 years lower than in healthiest areas of the UK. Across this area there was a 10 year difference in mortality rates, linked to inequalities, between deprived and least deprived communities, the biggest cause of death being cancer and heart disease, linked to high levels of smoking, drinking and obesity (NHS South of Tyne & Wear, 2009).

Commented [K1]: Need something more recent about numbers of older people in SOTW / older drinkers as what I have found isn't too relevant/recent – problem being since demise of PCTs SOTW no longer exists and trying to find anything relevant and up to date is beating me

Design

This mapping study was part of a wider study (Lock et al 2010) commissioned by Age UK. This study used the Age UK definition of 'older people' as being individuals aged 50 and over. The researcher (KM) contacted services within the geographical study area by telephone. Services contacted provided interventions around drug and alcohol use, older people, mental health and wellbeing, housing and community development. Services contacted were:

- listed in NHS South of Tyne & Wear Alcohol Services Directory
- identified within interviews
- known to the research team.

Local Drug and Alcohol Action Teams and Supporting People Teams were also contacted.

Service managers were interviewed, where unavailable, their deputy participated. Telephone discussions were guided by a semi-structured interview schedule.

Findings

Forty-six service providers were identified. In relation to the Models of Care for Alcohol Misusers (2006) specifications [1]

- 33 provided information, advice, screening, simple brief-interventions and referral (Tier 1)
- 9 provided open access, non care-planned alcohol specific interventions and/or community-based, structured, care-planned alcohol treatment (Tier 2 & 3)
- 4 provided specialist inpatient treatment and rehabilitation (Tier 4)

Only one service; Alcohol Link, Turning Point Gateshead[2] provided a specific intervention for older drinkers. Other organisations that provided any alcohol-related interventions typically provided

[1] In 2006, the National Treatment Agency for Substance Misuse [NTA] proposed that services commissioned to address adult alcohol misuse should provide equity of access, serve the whole population yet be designed to meet the diverse needs existing within local communities and address the health and wider societal risks associated with alcohol use and misuse. The Models of Care for Alcohol Misusers (2006) is a four-tiered conceptual framework of interventions provided by a wide range of generic and specialist service providers.

[2] Alcohol Link, Turning Point Gateshead – A one year pilot funded by Scottish & Newcastle that supported individuals not currently accessing treatment services for alcohol issues to access treatment and other supportive organisations. The service worked on an outreach basis, seeking to identify people aged 50+ and also worked in conjunction with the

adult services; for age 18 upwards with no upper-age limit. These services reported being fully-inclusive and non-discriminatory in relation to age. Many services promoted mixed-age support groups, underpinned by the rationale that people of differing ages had differing experiences to share to help and support others. Some organisations provided services specifically for younger people – typically aged under 18.

In services providing interventions for clients who used several drugs, use was recorded either as polydrug-use or one drug was recorded as the primary drug used. Where alcohol was one of several drugs used, it was typically not recorded as the primary drug.

Among providers, there was no definitive definition of an older person; many asked the researcher; 'What do **you** mean by an older person?' Data collection procedures of many organisations did not enable them to confirm whether older people were accessing services. While age was routinely collected, it was not used to monitor the numbers of older people (or other age groups) attending.

Respondents stated that older people formed only a small part of their client base, however there was no common reason why this was so. Some suggested it could be because few older people experienced alcohol-related issues, others suggested it could be because no dedicated older peoples' services were available. Some suggested alcohol users were less likely to maintain chaotic lifestyles into older-age because:

- Physical effects of ageing can reduce alcohol tolerance
- Medication for physical conditions can restrict alcohol use.
- Individuals whose alcohol use is heavy, chaotic and/or prolonged often experience other factors that negatively impact upon morbidity and mortality.

Discussion

This study identified a lack of alcohol services for older people within the South of Tyne area. This reflects national research; Wadd et al (2011) found only five UK substance misuse agencies who provided older peoples' services, only three of which operated in England.

Many services contacted within this study provided adult services which respondents considered non-discriminatory in relation to age. However, elsewhere we found that even when services were developed to be non-discriminatory, older people reported experiencing indirect discrimination resulting from, for example, marketing materials aimed at younger people, venue decor and age of staff (Lock et al 2010).

Fire Service with people who have experienced alcohol-related fires. The project provided harm minimisation and general alcohol advice and support to access treatment services.

Participating organisations did not define 'older' or monitor the numbers of older people accessing their services. If no consensus exists among commissioners or providers around 'older' and funding is not directed to support the development of services for older people then establishing the scale and scope of the issue and the need for services will continue to remain largely unquantifiable.

Services contacted typically focussed service provision around mixed-age groups which respondents considered were beneficial for clients, specifically around peer support and experience sharing. However, elsewhere, we found that older people were reluctant to access drug and alcohol services because they considered their alcohol use to be different to that of both younger alcohol users and users of other drugs (Wilson et al 2013). Similarly, existing evidence highlights that interventions developed specifically for older people produce higher success rates than those for mixed-age groups (Wadd 2011, RCP 2011).

Evidence shows that treatment interventions for older people can be effective (RCP 2011) and that the organisational cultures and expertise within mainstream adult services do not always meet the specific and often complex needs of older people (Wadd et al 2011). We suggest that rather than focussing upon non-discrimination in relation to age, generic adult services and adult drug and alcohol services need to be developed that are more sensitive to the specific needs of older alcohol users.

Conclusion

To enable provision of alcohol services to meet the needs of older people, commissioners and service providers need greater understanding of the patterns of drinking in later life, the scale and the scope of the issue and guidance as to the most appropriate action to take. An awareness of the issues related to alcohol use in later life also needs to be fully integrated into wider commissioning of other services that impact upon older people such as falls prevention, community based services, independent living and homecare services.

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