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The Older People’s Drug and Alcohol Project has been conducted by the Mental Health and Drug and Alcohol Office (MHDAO), NSW Ministry of Health, with advice and input from the project’s Expert Advisory Group. A full list of members of the Expert Advisory Group is included at Appendix D: EAG Membership. The MHDAO project team comprised representatives from the Older People’s Mental Health Policy Unit, the former Drug and Alcohol Clinical Standards and Design team (now Clinical Standards and Design team), Opioid Priorities and Partnerships, and Human Services and Criminal Justice Partnerships.

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Glossary

- **Abstinence**: Refraining from the use of a drug or drugs.
- **Addiction**: Physical and psychological craving for a drug or drugs and related behaviours. The process of addiction is progressive and chronic. The state of addiction is more commonly referred to as a varying state of dependency (National Centre for Education and Training on Addiction (NCETA), 2002).
- **Ageism**: Prejudice or discrimination on the grounds of a person's age. This has been used in the context of this report to encompass a range of ageist beliefs and actions regarding access to and validity of service provision for older people with drug and alcohol issues.
- **Alcohol and Other Drugs**: Drug and alcohol (D&A) and alcohol and other drugs (AOD) are used interchangeably in this report. The four main categories of substances considered in this report are alcohol, illicit substances (such as heroin, amphetamines, cannabis etc.), non-medical use of medications (both prescription and over-the-counter), and tobacco.
- **Alcohol misuse**: This term is used throughout the report to indicate drinking alcohol at unsafe levels. It is deliberately broad and not defined by number of standard drinks, for example, as safe levels of alcohol use for older people vary in accordance with a range of individual factors.
- **ASSIST**: The Alcohol, Smoking and Substance Involvement Screening Tool. The ASSIST was developed for the World Health Organisation (WHO) by an international group of substance abuse researchers to detect and manage substance use and related problems in primary and general medical care settings.
- **AUDIT**: The Alcohol Use Disorders Identification Test. The ten item tool was developed by the World Health Organisation (WHO) as a simple method of screening for excessive drinking and to assist in brief assessment. It is intended to identify hazardous and harmful drinking as well as alcohol dependence. Scores between 8 and 15 indicate hazardous drinking, scores between 16 and 19 suggest brief counselling and continued monitoring, and AUDIT scores of 20 or above clearly warrant further diagnostic evaluation for alcohol dependence.
- **AUDIT-C**: The AUDIT-C is a three question screen, comprised of the consumption questions of the AUDIT, which can help identify clients with alcohol misuse. The AUDIT-C is scored on a scale of 0-12 points (scores of 0 reflect no alcohol use in the past year). In both men and women 4 points or more is considered positive for alcohol misuse. Generally, the higher the AUDIT-C score, the more likely it is that the client's drinking is affecting his/her health and safety.
- **Client centred / client centred care (also known as person centred care or patient centred care)**: Treatment and care provided by health services that places the person at the centre of their own care, and considers the needs of the person's carers (Victorian Government Department of Human Services, 2003).
- **Consumer directed care**: Principles underpinning consumer directed care in the aged care sector include consumer choice and control, entitlement of the older person to access individualised supports, respectful and balanced partnerships, participation, wellness and reablement, and transparency (National Aged Care Alliance, 2013). Additionally, as part of the Commonwealth Aged Care Reforms, care packages named 'Consumer directed care packages' are available and involve greater direction from the consumer regarding makeup and budgeting of the package.
- ** Dependence**: Particular behavioural, cognitive and physiological effects that may arise through repeated substance use. Psychological characteristics of dependence include a strong desire to take the drug, impaired control over use, persistent use despite harmful consequences, and the prioritisation of drug use over other activities (NCETA, 2002).
- **Harm minimisation**: Strategies which aim to promote better health, social and economic outcomes for both the community and the individual. Harm minimisation includes preventing anticipated harm and reducing actual harm. Licit and illicit drugs are targeted. A comprehensive approach to drug-related harm, involving demand reduction, supply reduction and harm reduction strategies (NCETA, 2002).
Harm reduction: This approach seeks to find a pragmatic position based on acknowledging that many in society will continue to use drugs irrespective of the legal frameworks or the moral imperatives to not use. Harm reduction advocates promote such options as clean needles and syringe programs, the provision of prescription heroin as a treatment option and supervised injecting facilities (Evans, 2001).

Healthy/positive ageing: Healthy ageing is often used interchangeably with positive ageing, active ageing, successful ageing, and productive ageing. There is broad consensus that healthy ageing involves more than just physical or functional health. WHO defines active ageing as ‘the process of optimizing opportunities for health, participation and security in order to enhance quality of life as people age’ allowing people to ‘realize their potential for physical, social and mental well-being throughout the life course’.

Integrated care: Integrated care involves the provision of seamless, effective and efficient care that reflects the whole of a person’s health needs; from prevention through to end of life, across both physical and mental health, and in partnership with the individual, their carers and family. It requires greater focus on a person’s needs, better communication and connectivity between health care providers in primary care, community and hospital settings, and better access to community-based services close to home (NSW Health, 2014).

Intoxication: The effects of a drug on a single occasion of use when taken in a sufficiently large quantity to alter one’s state of consciousness. Also referred to as acute drug effects. Intoxication can range from mild to severe (NCETA, 2002).

Late onset/early onset (regarding alcohol disorders): Late onset as described in the literature is when problem drinking commences after the age of 25, whereas in practice and in the context of this project late onset is often used to describe onset as an older adult.

Mini Mental State Examination (MMSE): A brief test of cognitive function used to screen for dementia and other cognitive impairments.

Morbidity: Ill health experienced at either an individual or population wide level (NCETA, 2002).

Older old and younger old cohorts: A full description of the project target population and the two broad cohorts is included in the scope description from page 2. Briefly, in the context of this report, ‘younger old’ is used to describe the cohort of the target population who are aged 50-64 with substance use issues and who experience premature ageing, likely due to a long history of substance abuse. ‘Older old’ is used to describe the cohort of the target population who are aged 65+ with substance use issues, who have experienced a range of ages of onset.

Older person/older adult: For the purpose of this project, people aged 50 and over are in scope as ‘older people’, noting the cohort differences as above, and the differences in service planning age targets.

Opioid pharmacotherapy treatment/opioid substitution therapy: See Opioid Treatment Program.

Opioid Treatment Program: Refers to the NSW Opioid Treatment Program (OTP). The OTP delivers pharmacotherapy and associated services to opioid dependent patients in NSW and seeks to reduce the social, economic and health harms associated with opioid use. This is a form of Opioid Pharmacotherapy Treatment (OPT)/Opioid Substitution Therapy (OST).

Prevention: An intervention designed to change the social and/or environmental determinants of drug and alcohol abuse, including discouraging the initiation of drug use and preventing the progress to more frequent or regular use among at-risk populations (United Nations Demand Reduction Glossary of Terms, 2000).

Reablement: In the aged care/aged health sector, reablement is care that aims to help people learn or re-learn the skills necessary for daily living, which have been lost through deterioration in health and/or increased support needs.

Recovery: This term can have variable meanings in its usage within the drug and alcohol sector, including referring to abstinence. From the mental health perspective, recovery is an important overarching policy directive and has a complex meaning: ‘gaining and retaining hope, understanding of one’s abilities and disabilities, engagement in an active life, personal autonomy, social identity, meaning and purpose in life, and a positive sense of self. It is important to remember recovery is not synonymous with cure’ (Australian Government, 2010). Due to these significant differences, the intended audience and meaning has been made clear throughout the report.
- **Recovery-oriented care:** The principles of recovery-oriented mental health practice ensure that mental health services are delivered in a way that supports the recovery of mental health consumers. The principles focus on the uniqueness of the individual; real choices; attitudes and rights; dignity and respect; communication and partnership; and evaluating recovery.

- **Specialist/specialist worker:** A specialist staff member will carry different connotations to different sectors. For example in general health services, a specialist is likely to be used to describe a doctor specialising in a certain area of medicine. In drug and alcohol services, a specialist may mean a specialist in the field of addiction medicine. In practice, among general health and mental health services, all drug and alcohol workers are ‘specialist drug and alcohol workers’. This report has attempted to clarify the intended meaning of any instances of the term specialist.

- **Substance use issues/problems:** For the purposes of this report the general term ‘substance use issues’ has been used to describe a range of issues related to the four nominated groups of substances, including intoxication, dependence, hazardous use, non-medical use of medications, and withdrawal.

- **Therapeutic nihilism:** A disbelief in the efficacy or value of therapy or intervention. This is used in the context of this report to describe members of the health/drug and alcohol/mental health workforce being skeptical of there being any value in attempting to provide treatment for an older person’s drug and alcohol issue.

- **Warm referral:** A more assertive approach to referral, where the individual making the referral makes first contact on behalf of the client, and explains to the referral organisation or team the client’s circumstances and the reason they believe the client would benefit from the referral.
Acronyms

- ACI Agency for Clinical Innovation, NSW Health
- ADAN Aboriginal Drug and Alcohol Network
- AH&MRC Aboriginal Health and Medical Research Council
- AIHW Australian Institute of Health and Welfare
- A-ARPS Alcohol Related Problem Survey (Australian version)
- ASSIST Alcohol, Smoking and Substance Involvement Screening Test
- AUDIT Alcohol Use Disorders Identification Test
- AUDIT-C Alcohol Use Disorders identification Test, Consumption questions
- CALD Culturally and Linguistically Diverse
- CBT Cognitive Behaviour Therapy
- CHOC Community Health and Outpatient Care (data system)
- CL Consultation Liaison
- COPD Chronic Obstructive Pulmonary Disease
- CTO Community Treatment Order
- D&A Drug and alcohol
- DACL Drug and Alcohol Consultation Liaison
- EAG Expert Advisory Group
- GP General Practitioner
- IDAT Involuntary Drug and Alcohol Treatment
- IRIS Indigenous Risk Impact Screen
- LHD Local Health District
- LGBTI Lesbian, Gay, Bisexual, Trans/Transgender and Intersex people and other sexuality and gender diverse people
- MDT Multi-Disciplinary Team
- MHDAO Mental Health and Drug and Alcohol Office, NSW Ministry of Health
- MH-OAT Mental Health – Outcomes and Assessment Tools
- MMSE Mini Mental State Exam
- MoCA Montreal Cognitive Assessment
- MSIC Medically Supervised Injecting Centre
- NADA Network of Alcohol and Other Drugs Agencies
- NCETA National Centre for Education and Training on Addiction
- NDARC National Drug and Alcohol Research Centre
- OPDA Older people’s drug and alcohol
- OPMH Older people’s mental health
- OPT Opioid Pharmacotherapy Treatment
- OST Opioid Substitution Therapy
- OTC Over the counter
- OTP Opioid Treatment Program
- PRISM-E Primary Care Research in Substance Abuse and Mental Health for the Elderly
- RCT Randomised Control Trial
- RUDAS Rowland Universal Dementia Assessment Scale
- SIBRT Screening, brief intervention, and referral to treatment
- SMHSOP Specialised Mental Health Services for Older People
- US United States
- WHO World Health Organisation
- WKS Wernicke-Korsakoff Syndrome
Executive Summary and Recommendations

Project, Policy and Literature Context

The Older People’s Drug and Alcohol Project seeks to identify the key issues relevant to older people with substance use issues, including those with comorbid mental health issues, and existing service models and good practice responses for this population. The project’s focus is on NSW Health and NSW Health-funded drug and alcohol and mental health services, and ultimately, the project aims to improve the responses of these services to the needs of older people with substance use issues. Direct recommendations for the aged care and aged health sectors are out of scope for this project, although the project work conducted and reflected in this report highlights some key issues for these sectors and is intended to inform and encourage further work in the area.

The purpose of the full report is to provide a comprehensive resource for services, detailing this initial policy project work in the area. The accompanying summary report also includes recommendations and will be a useful, concise resource document for services. The third resource, the ‘report in brief’, is aimed at a broader audience and highlights the key issues and messages arising from the project.

Generally speaking, older people have the lowest rates of alcohol misuse, illicit drug use and tobacco consumption but the highest rates of prescription drug misuse (Australian Institute of Health and Welfare (AIHW), 2011 & 2014b). However, the age of people accessing addiction-related services has been increasing (Holmwood, 2011; AIHW, 2014b). Because of the physiological changes associated with ageing, older people are at increased risk of adverse physical effects of substance misuse, even at relatively modest levels of intake (Royal College of Psychiatrists (RCPsych), 2011).

Prevalence rates need to be interpreted with caution given that substance misuse is often under-diagnosed and that a small number of people with disorders seek treatment (Aartsen, 2011). Substance misuse among older people is frequently under-reported (McGrath, Crome & Crome, 2005). Older people may show complex patterns and combinations of substance use, such as alcohol plus inappropriate use of prescribed medications (RCPsych, 2011).

There are also generational impacts going forward for substance misuse in older people. The ‘baby boomer’ generation started turning 65 in 2011. A US study noted that the baby boomer generation have had more exposure to alcohol, tobacco and illegal drugs in their youth and tend to be more lenient about substance abuse (Wang & Adnrade, 2013). A small percentage of older people use illegal drugs. However, with the significant increases in illicit drug use in the 40+ age group demonstrated in national surveys, it can be anticipated that a significant increase will occur in older age ranges as this cohort ages (AIHW, 2014b; Gfroerer, Penne, Pemberton & Folsom, 2003; RCPsych, 2011). When these trends are combined with increasing numbers of older people associated with an ageing population, epidemiological indicators demonstrate a likely significant increase in the number of older people with substance use issues in the near future (DrugScope, 2014).

There are no specific national or state policy frameworks related to older people’s drug and alcohol use. However, there are a number of state and national policy documents and clinical guidelines that highlight older people and/or the ageing population as a specific population group. Additionally, a number of state drug and alcohol guidelines are in the process of revision and this project may inform specific content relevant to older people. Furthermore, this is an area of growing interest and activity nationally and internationally.

Project approach and scope

The project has been conducted through collaboration between older people’s mental health (OPMH) and drug and alcohol clinical policy teams within the NSW Ministry of Health Mental Health and Drug and Alcohol Office (MHDAO). It has been overseen by MHDAO and informed by consultation and advice from key stakeholders. An Expert Advisory Group (EAG) was formed to provide advice and guidance on the project and further oversight has been provided through existing mental health and drug and alcohol governance and advisory mechanisms.
The project scope and focus is on NSW drug and alcohol and mental health services. However, some broader strategic and service interface issues have also been highlighted, and are included in the report and recommendations.

The agreed target group definition is people aged 50 years and over with substance misuse issues. This includes those who are at risk of developing a substance use disorder at the age of 50 years and over, or those who have a long standing substance use disorder. Within this large age range, two primary cohorts have been identified, referred to as the ‘younger old’ and the ‘older old’.

‘Younger old’ broadly refers to younger people from the age of 50 experiencing premature ageing-related functional and physical decline associated with long standing substance misuse. This may include complex morbidity issues including dementia or acquired cognitive impairment. ‘Older old’ refers to those aged 65 and over, and includes people with a broader range of ages of onset and current health status. Aboriginal people are considered in scope for the purposes of the project from 50 years of age, in line with national aged care planning processes.

Drug and Alcohol Issues in Older People

The four main groups of substances used in the context of this project are alcohol, illicit drugs, medication misuse, and tobacco.

Alcohol: Alcohol is the most common drug used by older people (AIHW, 2011 & 2014b). Older people in Australia are less likely to binge drink, but are the most likely age groups to be daily drinkers (AIHW 2011 & 2014b). The negative health effects of alcohol increase with age, in addition to age-specific potential harms such as increased medication interactions and risk of falls and social isolation.

Moderate alcohol use can have positive social impacts and potentially protective health impacts (although evidence is variable). A key issue is that there are no clearly defined definitions of moderate and unsafe drinking levels for older people, and that a variety of individual and health factors will impact on a safe level of consumption for each person.

Illicit drugs: Illicit drug use can have negative impacts on health status, quality of life, and on family and social relationships that accumulate with age, and it has been noted that the long term cognitive effects of illicit substances are largely unknown.

Many drug and alcohol treatment populations, such as people on maintenance opioid substitution therapy, are ageing (AIHW, 2014a). They are now experiencing ageing-related health problems and service access issues for the first time. Additionally, there are emerging trends regarding cannabis use increasing amongst older people, most likely in line with the ageing of the baby boomers (AIHW, 2014b). The long term cognitive effects of cannabis and its impacts on health as we age are not well understood.

Medication misuse: Misuse of prescription drugs among older adults can range from sharing medications and using medications at higher dosages or for longer periods of time than prescribed, to persistent abuse and dependency issues. The two main classes of medications that present a concern for abuse are the benzodiazepine sedative-hypnotics and the opioid analgesics. Although there is not yet clear evidence, the misuse of psychotics is an emerging trend within the misuse of pharmaceuticals, with quetiapine being of particular concern.

Tobacco: In addition to the well published health risks for all smokers, there are specific risks pertaining to older people including smoking being a risk factor for cognitive decline and dementia, and having implications for medication metabolism.

Specific groups and considerations

There are a number of particularly vulnerable sub-groups of people aged 50+ with substance use issues, with specific or complex needs. In addition, the issues of multiple morbidities, cognitive impairment and pain are significant when considering issues and needs of older people with substance use issues.

Needs of older people with substance use issues, and key issues arising from consultations

Consulted stakeholders were invited to comment on the needs of older people in accessing and using services and treatment, and also the key issues for older people with substance use issues. Many of the responses echo the findings in the literature.

Needs identified during the consultations related to mobility and transport, accommodation, and an integrated or complex care approach. Decision making support and options for involuntary care were highlighted as needs for older people with significant cognitive impairment following a long history of substance abuse.
Key issues for older people with substance use issues identified by consulted stakeholders are numerous and disparate, reflecting the large age range in people aged 50 years plus and the different issues for the different cohorts. The more commonly identified key issues include: cognitive impairment; recognition of substance use issues; ageism and therapeutic nihilism among the general community and health professionals; physical health issues; accommodation, finances and transport issues; the traditional approach of drug and alcohol services not aligning with the needs of older people; social isolation; lack of targeted health promotion activity; challenges in engaging carers; and the tension between voluntary and assertive treatment approaches and service structures.

Services and Service Issues

Services and Service Delivery

Services available

In order to identify services relevant to older people with drug and alcohol issues, and also provide a reference resource to the varying sectors using this report, a service mapping exercise has been undertaken to describe the key elements of NSW Health drug and alcohol services, specialised mental health services for older people (SMHSOP), and adult mental health services. This is included in Section 3A ‘Service Mapping’.

Service utilisation

NSW Health service utilisation data has been extracted and analysed to demonstrate use of NSW drug and alcohol and mental health services, as well as hospital inpatient admissions, by older people with drug and alcohol diagnoses in the past ten years. This data is included in more detail in Section 3A ‘Service Utilisation Data and Analysis’. The data supports the perception of increasing service use and need with the arrival of the baby boomer generation in the target age range.

In broad terms, the data demonstrates that the impacts of increasing numbers/prevalence of older people with substance use issues, particularly the baby boomer generation, are mostly seen in adult mental health inpatient services, and drug and alcohol ambulatory services. The data does not tell us whether changes are being driven by population increase in the baby boomer generation, or whether there is a cohort effect of different patterns of substance use, although the latter is implied and supported by the literature. It is still unclear whether the trends in the 50-64 year old cohort over the past decade will persist into the 65+ year old cohort, but this is likely to be the case.

Barriers to service access

The primary identified barriers to service access by older people with substance use issues are recognition and stigma. Other barriers relate to the availability and knowledge of services, and lack of established referral pathways.

Workforce issues

A range of workforce-related issues were raised by consulted stakeholders. Older people with substance use issues are emerging as a group that currently have high unmet needs as well as indicators that suggest they will require significantly more health services over time. This presents challenges that will require a workforce development response, as well as a service delivery and development response.

Referral issues and service interfaces

A key issue in this project relates to integration of and collaboration between services and sectors, particularly drug and alcohol services, mental health services, aged health or hospital services, and primary care.

Clinical processes and service delivery arrangements that work

The strongest theme arising from the literature is the need for improved liaison and stronger collaborative models to be developed and implemented between aged or general health services, primary care and mental health and drug and alcohol services. Further key themes and recommendations are that practical barriers should be addressed, such as by providing home visits, and that addressing older people’s coexisting physical health needs should be considered an integral part of their overall management.

Clinical Practice

Screening and assessment

Screening is an important component of improving responses to the needs of older people with substance use issues, in the context of low recognition. A screening test should be used as the first step in a process that should involve screening, brief intervention, and referral to treatment (for comprehensive assessment and formal diagnosis), according to screen outcomes and service setting. This approach is widely supported in the literature for use in primary care and general health care settings.
Comprehensive assessment is also important, especially when the older person may receive symptomatic treatment (such as sedative hypnotics for sleep problems) instead of intervention targeting the full range of symptoms.

A range of screening tools are available. However, it is important to note that existing screening instruments may not be appropriate for older people and screening instruments for prescription drug abuse have not been validated in the geriatric population. Lower cut off points have been researched for many screens, but the cut off score found to be most valid varies in the literature. Screening for cognitive impairment is another important component of clinical practice. There are a multitude of cognitive screens available, and local consistency with referral partners is important.

**Intervention**

There is a paucity of research evidence nationally and internationally on specific best practice approaches and service models for older people with drug and alcohol issues. The available evidence and expert opinion indicate that older people can respond equivalently to younger cohorts to mixed aged treatments; and that more treatment in terms of length of stay or treatment adherence results in better outcomes for older people.

Age-specific treatments appear to improve outcomes and service acceptability for older clients, and can involve:

- tailoring information to the age group, such as education about unique medical vulnerabilities to alcohol and combining medications
- physical adaptations to treatment such as an accessible location or a slower pace of treatment, and/or
- psychosocial adaptions to treatment such as group therapy with topics relevant to life stage, e.g. coping with loss, grief, loneliness and life transitions.

**Broader Strategic Issues**

The focus of this project concerns improving the responses of NSW Health and NSW Health-funded drug and alcohol and mental health services to the needs of older people with drug and alcohol issues. However, population health and health literacy issues, service sector interfaces, accommodation issues, and research gaps have been highlighted through the project processes as being key strategic areas for consideration in addressing issues surrounding older people’s substance misuse.

These issues are highlighted further in ‘Section 4: Broader Strategic Issues’.

**Summary and Recommendations**

This report describes the project’s target population and project purpose, and highlights some key themes relevant to older people and substance misuse. It also describes existing services available in NSW, noting factors that can act as barriers to service access for older people, as well as highlighting enablers, age-appropriate service design and elements, and positive practice examples.

Older people with substance misuse problems are a diverse group with diverse needs. A range of recommendations are therefore indicated for NSW Health drug and alcohol and mental health services, from age-appropriate treatment and support of extended duration for those who are drug and/or alcohol dependent, to brief interventions for those whose substance use places their health at risk (DrugScope, 2014). In addition to these recommendations for NSW Health drug and alcohol and mental health staff and services, the literature review, consultations and analysis conducted for the project supports some broader recommendations pertaining to: support for those with issues with prescription and/or over-the-counter medications and the staff involved in their provision and monitoring; appropriate accommodation options for people across a spectrum of needs, and population health strategies.

Before proceeding to recommendations, it is worthwhile highlighting that a range of outcomes may be appropriate and desirable for older people with drug and/or alcohol problems, in the context of person centred, holistic assessment and care. These outcomes might involve abstinence for some older people with substance use disorders, as well as a wide range of other outcomes focused on harm minimisation, improved health, and increased levels of wellbeing and social connectedness (DrugScope, 2014). Additionally, whilst recommendations for the aged care and aged health sectors are out of scope for this project, the report highlights some key issues and is intended to inform and encourage further work in this area.

Recommendations are broken down into: recommendations relating to MHDAO, NSW Ministry of Health (in collaboration with other parts of the Ministry and through advice to other relevant policy makers and services), recommendations for NSW drug and alcohol services, recommendations...
for NSW mental health services, and additional recommendations regarding priorities for further research. The recommendations are as follows, with a more detailed version that includes examples, strategies and supporting information included at ‘Appendix A: Annotated project recommendations’.

**Recommendations for MHDAO**

1. MHDAO should support a focus on addressing substance use in older people in policy, planning and service delivery in a range of sectors across NSW and nationally.

   Key implementation strategies or markers will include:

   - Disseminating this report and associated documents widely, and communicating key findings through a range of forums and mechanisms.
   - Using this report to highlight key areas for further investigation and policy/service development regarding older people with substance use issues that were beyond the scope of the project (including aged health and hospital service responses, community and residential aged care service options, service options for older people with substance use disorders and cognitive impairment requiring supported care – particularly those under 65 years – and strategies around pharmaceutical misuse in older people).
   - Ensuring that statewide efforts to enhance service user/consumer consultation and engagement across the drug and alcohol and mental health programs include a focus on older people with drug and alcohol issues.
   - Using the findings and recommendations of this report to ensure the needs of older people with substance use issues, including prescription drug misuse, are appropriately addressed within:
     - NSW drug and alcohol and mental health planning models;
     - All relevant NSW Guidelines due for review, such as the NSW Health Drug & Alcohol Psychosocial Interventions – Professional Practice Guidelines and the Drug and Alcohol Withdrawal Clinical Practice Guidelines – NSW, and the NSW Opioid Treatment Program: Clinical guidelines for methadone and buprenorphine treatment of opioid dependence; as well as in the development of new policies and guidelines, and
     - Quality/service improvement initiatives in drug and alcohol services and mental health services across NSW.

2. MHDAO should use the findings and recommendations of this report to inform statewide workforce and practice development initiatives in drug and alcohol and mental health services across NSW.

3. MHDAO should provide advice to the Centre for Population Health to support health promotion activity focused on older people and substance misuse.

   Key implementation strategies or markers will include:

   - The development of consensus information on safe drinking limits specifically for older adults.
   - The development of factsheets for the public and healthcare professionals regarding alcohol use and older people, highlighting the balance of benefits and risks with alcohol use and appropriate strategies to address social isolation as a risk factor for alcohol misuse (e.g. social activities and events).
   - Work with the primary healthcare sector to increase awareness of the need to engage in regular alcohol screening, the screening tools that are available and appropriate referrals to services, supported by factsheets and information materials.
   - The development of factsheets for the public and healthcare professionals regarding prescription drug misuse issues for older people.
   - Addressing smoking by older people in mental health and drug and alcohol services in the context of addressing smoking in NSW Health facilities and services, as well as within broader NSW population health and tobacco strategies.
   - MHDAO promoting the Get Healthy Information and Coaching Service, which includes an alcohol consumption module, through relevant drug and alcohol and mental health services.
**Recommendations for NSW drug and alcohol services**

4. When planning and delivering services within existing mixed age settings, drug and alcohol services (including Non-Government Organisations (NGOs)) should further develop their capacity to provide accessible and appropriate services for older people.

Key features of accessible and appropriate service responses include:

- The development of collaborative models with aged health services, older people’s mental health services and primary care services.
- Addressing the barriers for older people in accessing mixed age services (e.g. provision of outreach services and home visiting for appointments).
- Using the Drug and Alcohol Consultation Liaison (DACL) service as a key point of referral for older people with substance use issues in the inpatient system. There are also significant opportunities across the hospital system for improving recognition and screening of drug and alcohol issues in older people, including prescription drug misuse; brief interventions; and referral to specialist drug and alcohol services.
- Management of coexisting physical conditions and psychological conditions being incorporated into treatment.
- Withdrawal identification and management practices being implemented in line with the considerations related to older people set out in *NSW Drug and Alcohol Withdrawal Clinical Practice Guidelines (2008)*.
- Education of drug and alcohol staff on ageing-related issues.
- Key partnerships and relationships being developed and maintained, relevant to the local service context, to engage older Aboriginal people.
- Key partnerships and relationships being developed and maintained, relevant to the local demographics and service context, to engage older people from culturally and linguistically diverse (CALD) backgrounds. These may include migrant and refugee services.
- Key partnerships and relationships being developed and maintained, relevant to the local demographics and service context, to engage older people experiencing homelessness.
- The engagement of families and carers in drug and alcohol service provision.
- Drug and alcohol services and staff having a well-developed understanding of the other relevant services available locally and statewide, their target populations and referral arrangements.
- Specialist drug and alcohol services supporting interventions by non-specialist workers in the general health, mental health, and aged care sectors.
- Addressing the under-recognition of tobacco use by older people. One component of this response will include implementing the *Smoke-free Healthcare Policy* within their services.

5. Drug and alcohol services should consider providing targeted services for older people.

Examples of strategies to achieve this recommendation include clinics established in primary care settings, ‘one stop shops’, structured screening pathways and shared care arrangements supported by cross sectoral relationships and support, and targeted prevention and treatment activities (see Appendix A: Annotated Project Recommendations for further details).

6. Drug and alcohol services should develop their capacity to provide appropriate screening and assessment processes for older service users.

Key features of appropriate processes will include:

- Understanding that applying the standard diagnostic criteria may not always be appropriate for older people.
- Understanding that safe drinking limits for older people have not been established in Australia, and will vary from client to client.
- Understanding that prescription drug misuse is a significant and growing issue among older people, and considering this in assessment and screening processes.
- All older service users being screened for cognitive impairment. Local consistency regarding tool use is important, although some recommended screens include:
  - The Arbias Acquired Brain Injury Screen (in Community Health and Outpatient Care (CHOC) data system)
  - The Montreal Cognitive Assessment (MoCA)
  - The Rowland Universal Dementia Assessment Scale (RUDAS).
- All older service users having physical health examinations as an important part of care, with clear systems and pathways for care coordination and referral in place.
All older service users being asked their smoking status, with those who smoke being provided with brief intervention or more extensive smoking cessation support where required.

All older service users being screened for mental health problems, particularly depression, with referral to treatment as appropriate.

7. **Drug and alcohol services should develop their capacity to provide treatment interventions for older service users in a way that aligns with current consensus on good practice.**

Key features include:

- Treatment of coexisting physical conditions and psychological conditions
- Age-specific therapy groups or age-specific therapy times
- Age-specific withdrawal management or detoxification support
- Age-specific treatment approaches such as tailoring information to the age of the service user, utilising a slower pace of treatment, and/or psychosocial adaptations to treatment such as group therapy with topics relevant to life stage
- Carer identification and engagement strategies being implemented in the treatment process
- Strategies to address cognitive impairment being utilised
- Drug and alcohol services linking their older clients into meaningful community engagement activities
- Harm reduction strategies being utilised in accordance with person centred goal setting and service provision
- The use of psychosocial treatment interventions to address losses, and regular suicide risk assessment, as per *NSW Health Drug and Alcohol Psychosocial Interventions Professional Practice Guidelines* (2008).

**Recommendations for NSW mental health services**

8. **When planning and delivering services, mental health services should incorporate responses for older people with a primary or comorbid drug and alcohol issue.**

Key features of appropriate service responses include:

- The development of links/partnerships with drug and alcohol services for referral and joint management of consumers with serious substance misuse problems
- Services recognising and negotiating the stigma experienced by older people who may not identify as having a substance misuse disorder
- SMHSOP (and aged health services) providing expertise and support to drug and alcohol services in cognitive screening and assessment, and referral to appropriate aged care and community support services
- Utilisation of the DACL service as a key point of referral for older people with substance use issues (and comorbid mental health issues) in the inpatient system
- Withdrawal identification and management practices being implemented in line with the considerations related to older people set out in *NSW Drug and Alcohol Withdrawal Clinical Practice Guidelines* (2008)
- Addressing the under-recognition of tobacco use by older people. One component of this response will include implementing the *Smoke-free Healthcare Policy* within their services
- Mental health services developing workforce strategies such as:
  - Education and training of staff in order to be able to screen for and identify substance misuse issues, including the non-medical use of prescription and over the counter medication;
  - Education and training of staff in order to be able to provide brief interventions, and
  - Workforce support strategies where SMHSOP/adult mental health is the primary service supporting consumers with comorbidity or primary diagnosis of substance misuse.

9. **Mental health services should provide routine screening and assessment of older service users with regards to substance use issues, including prescription drug misuse.**

Key features include:

- Continued use of all screens in mandated Mental Health Outcomes and Assessment Tools (MH-OAT) systems, such as items in the triage and assessment modules, and the Mental Health Substance Use Assessment.
- Services understanding that applying the standard diagnostic criteria may not always be appropriate when screening older people for substance misuse, and that safe drinking limits for older people have not been established in Australia, and will vary from client to client.
- The use of recommended screening tools for alcohol and other substances
- For routine screening for alcohol use disorders, a recommended screen is the AUDIT-C (Alcohol Use Disorders Identification Test, Consumption questions; Bush et al, 1998)
- A recommended screen incorporating substances besides alcohol is the ASSIST (the Alcohol, Smoking and Substance Involvement Screening Tool, see http://www.who.int/substance_abuse/activities/assist/en/)
- The Indigenous Risk Impact Screen (IRIS) has been developed and validated for use with Aboriginal people, for screening for alcohol and other substance misuse (as well as mental health problems). It has not been validated for older Aboriginal populations but can be a more culturally appropriate option to consider using initially.
  - Services conducting a screen for cognitive impairment if there is a positive screen for substance misuse/alcohol misuse.
  - A positive screen for alcohol and/or substance misuse resulting in either the provision of brief interventions, or referral to specialised drug and alcohol treatment according to the level of risk or dependence indicated in the screen outcome.
  - All older service users being asked their smoking status, with those who smoke being provided with brief intervention, or more extensive smoking cessation support where required.

10. Mental health services should develop some capacity to provide clinical care and interventions for older service users with substance use issues.

Key features of appropriate clinical care and interventions should include:
  - Close collaboration and joint working with drug and alcohol services
  - Provision of brief interventions by mental health staff, if they have engaged in appropriate education and training
  - Mental health staff delivering brief interventions and ‘low risk drinking’ advice when working with older adults who are not dependent, but are drinking at risky or hazardous levels
  - The provision of interventions relevant to addressing cognitive impairment in the delivery of clinical care
  - The provision of interventions relevant to addressing social isolation, which may play an important part of addressing an older person’s substance misuse
  - The provision of interventions relevant to harm reduction, in accordance with person centred goal setting and service provision.

Recommendations for research funding bodies and organisations

11. Future research should be conducted in the area, in light of the many gaps in our current knowledge regarding the extent of substance use issues in older people and effective management.

Key areas for further research include:
  - Epidemiological understanding of prevalence and trends: Epidemiological research regarding the quantum of the problem and trends in the extent, nature and predictors of substance use problems in older people; and the intersection of age, culture and substance use.
  - Developing an evidence base on appropriate assessment and effective treatments for older people with substance misuse issues, including prescription drug misuse: standardised age-appropriate assessment and outcome measures that encourage comparability; and effective interventions for adults should be evaluated for suitability for older people.
  - Understanding barriers and enablers.
  - Development and evaluation of innovative treatments for older people, particularly:
    - Service models with a focus on long term outcomes;
    - Service models and treatment approaches that address the needs of older cognitively impaired people with substance misuse issues; and
    - Service models incorporating higher treatment doses/compliance strategies.
SECTION ONE

Introduction

Project, policy and literature context

**KEY POINTS: Project, policy and literature context**

Specific literature on best practice approaches is scarce, although there is growing awareness of the need for improved responses nationally and internationally.

Prevalence of substance use disorders is low among older people but is expected to grow with the ageing of the baby boomer generation, and prevalence rates need to be taken with caution due to under-recognition.

There are no specific relevant policies in NSW or Australia. Overarching policy concepts informing this project and report include harm minimisation, person centred care, integrated care, and recognition of carer roles.

The Older People’s Drug and Alcohol Project seeks to identify the key issues relevant to older people with substance use issues, including those with comorbid mental health issues, and existing service models and good practice responses for this population. The project’s focus is on NSW Health and NSW Health-funded drug and alcohol and mental health services, and ultimately, the project aims to improve the responses of these services to the needs of older people with substance use issues. Direct recommendations for the aged care and aged health sectors are out of scope for this project, although the project work conducted and reflected in this report highlights some key issues for these sectors and is intended to inform and encourage further work in the area.

The purpose of this full report is to provide a comprehensive resource for services, detailing this initial policy project work in the area. The accompanying summary report also includes recommendations and will be a useful document for services. The third resource, the ‘report in brief’ is aimed at a broader audience and highlights the key issues and messages arising from the project.

Substance use disorders and substance misuse in older people are associated with many health, mental health and social problems, including increased risk of hospitalisation, residential aged care placement and death. Older people with substance misuse problems may present to mental health services, aged care services, general practice, or hospital emergency departments with a range of other mental and physical health problems. In many instances their underlying substance use issues may go unrecognised.

The ageing of Australia’s population is well documented, with the population of people aged 65 and above projected to increase from 13% in 2007 to between 18% and 20% in 2026 (Australian Bureau of Statistics (ABS), 2008). People aged 65 years and over living in NSW represent 14% of the total population. In line with the increase in the age of the Australian population, and international research, the prevalence of substance use disorders in older people in NSW can reasonably be anticipated to increase. The increasing prevalence and under-recognition of substance misuse will present challenges for services in responding to the needs of older people with substance use issues into the future.

Generally speaking, in Australia older people have the lowest rates of alcohol misuse, illicit drug use and tobacco consumption but the highest rates of prescription drug misuse. However, the age of people accessing addiction-related services has been increasing (AIHW, 2014b; Holmwood, 2011). In Australia, 15% of older people consume alcohol daily, 8% of older people use tobacco daily and 3% use pain killers or non-opioid analgesics for non-medical purposes (Hunter & Lubman, 2010). Due to the physiological changes associated with ageing, older people are at increased risk of adverse
physical effects of substance misuse, even at relatively modest levels of intake (Royal College of Psychiatrists (RCPsych), 2011).

Prevalence rates need to be interpreted with caution given that substance misuse is often under-diagnosed and under-reported, and that a small number of people with disorders seek treatment (Aartsen, 2011; McGrath, Crome & Crome, 2005). Part of the issue is that older people can show complex patterns and combinations of substance use, such as alcohol plus inappropriate use of prescribed medications, and present with a range of comorbidities (Draper et al, 2015; RCPsych, 2011).

In the United States (US), the estimated prevalence of older people with alcohol use disorders varies from 4% to up to 16% (Menninger, 2002). However, prevalence rates may be higher (up to 22%) amongst medical inpatients, those receiving outpatient psychogeriatric care and those presenting to emergency departments (Keurbis & Sacco, 2013). One study estimated that only 1% of older adults admitted to the hospital were referred for substance abuse (including alcohol) consultations, and proposed that these results suggested that substance use disorders in elderly patients are under-diagnosed and under-treated in the hospital setting (Weintraub et al, 2002). Substance issues among people aged 50 years and over are rapidly increasing in Europe and the US (Aartsen, 2011). In the US, there is increasing evidence of substantial cocaine, heroin and prescription drug misuse. However, alcohol remains the most commonly used substance by older people in the US and Australia (AIHW, 2014b; Keurbis & Sacco, 2013).

There are also generational impacts going forward from substance misuse in older people. A number of studies in Australia, the US and the United Kingdom (UK) have highlighted that the ‘baby boomer’ generation have had more exposure to alcohol, tobacco and illegal drugs in their youth and tend to be more lenient about substance abuse. There has also been ageing of drug using populations, and with the significant increases in illicit drug use in the 40+ age group, it can be anticipated this will carry over into older age ranges as this cohort ages. These trends, combined with overall population ageing, with people living longer, generally healthier lives, with more disposable income in their later years, highlight the need to consider responses to substance misuse in older people (AIHW, 2014b; Draper et al, 2014; Nicholas & Roche, 2014; RCPsych, 2011; Wang & Adnraade, 2013).

A significant tension is present in the space of older people’s drug and alcohol use; that of the potential health and longevity benefits of moderate use of alcohol (Reid et al, 2002) and older adult’s social engagement and socialisation potentially involving moderate use (Dare, Wilkinson, Allsop, Waters & McHale, 2014; Wilkinson & Dare, 2014), while alcohol misuse can have significant adverse health impacts. It is important to note that ‘moderate use’ does change with increasing age and with a variety of individual characteristics; and that moderate use in relation to older people is lower than for adult populations. Whilst much of this report necessarily focusses on improving services’ responses to the needs of older adults with substance misuse issues, it is important to recognise the potential social and physical benefits of moderate use, and the importance of person centred care. A range of treatment goals or outcomes may be appropriate when considering treatment plans with older people, and holistic assessment and collaborative goal setting are imperative to the process.

The four identified subgroups of substance use disorders in this project are related to alcohol, medication misuse, illicit substances and tobacco. Whilst there are no specific national or state policy frameworks focussing specifically on older people’s drug and alcohol use, the following policy documents and clinical guidelines highlight older people and/or the ageing population as a specific population group and highlight some key issues:

1. National Tobacco Strategy 2012-2018
2. NSW Tobacco Strategy 2012-2017
7. Model of Care Involuntary Drug and Alcohol Treatment (IDAT) Program Version 4
10. The NSW Service Plan for Specialised Mental Health Services for Older People (SMHSOP) 2005-2015
1. The National Tobacco Strategy 2012-2018 and the NSW Tobacco Strategy 2012-2017 do not specifically identify older people as a priority population group. However, the identified priority groups in these strategies may include older people. They include low socioeconomic groups, Aboriginal people, those who are unemployed, homeless or imprisoned and those with a mental illness or drug or alcohol dependency, and some culturally and linguistically diverse (CALD) groups.

2. The National Drug Strategy 2010-2015 recognises the challenge of long term drug use and misuse among adults and the new challenges that an ageing population may pose, and acknowledges the projected increases in the population of Australians aged over 65 years. The Strategy highlights some particular problems with drug misuse for older people, including interactions with prescribed medications; under-recognition and treatment of alcohol and drug problems; unintentional injury and social isolation; and those associated with alcohol, including increasing the risk of falls, motor vehicle accidents and suicide in older people. The NSW Drug and Alcohol Plan 2006-2010 highlights the greater need for support services due to increasing age coupled with effects of drug or alcohol misuse resulting in lowered ability to cope in the community.

3. The National Pharmaceutical Drug Misuse Framework for Action 2012-2015 describes the spectrum of pharmaceutical drug misuse problems as encompassing those who unintentionally misuse medications in response to inappropriate prescribing techniques, through to those who intentionally obtain and misuse medications for their non-therapeutic effects and/or financial gain. The Framework highlights that as Australia’s population ages, the prevalence of painful conditions will increase, as well as the prevalence of psychological disorders such as anxiety, which means the population level demand for medications such as opioids and benzodiazepines could be expected to increase. It also poses the question whether opioids are the best treatment options for these conditions, and provides evidence to the contrary. The Framework identifies that pharmacotherapy is a central component of medical care for older Australians, with approximately two-thirds of Australians over the age of 60 years regularly using 4 or more drugs, and that the use of the benzodiazepines temazepam, oxazepam, and nitrazepam peaks among Australians aged 90-94 on a defined daily dose per population per day basis. The Framework also highlights the need to ensure that the standards for prescribing, dispensing, and administering medications in residential aged care facilities contributes to the quality use of these medications, and the issue that staff in this setting tend to be less qualified than in other health care settings.

4. The National Drug and Alcohol Psychosocial Interventions – Professional Practice Guidelines (2008) also emphasises that there are a range of losses that can be a focus for psychosocial interventions. The Guidelines provide strategies to address memory problems in the treatment context, as well as highlighting the need to engage in regular suicide risk assessment due to the high rates of suicidality in the over 65 age group. The Guidelines state that psychosocial treatment plans with older clients can be expected to produce significant and sustainable change in problematic drug and alcohol use.
7. Older people are a special population group under the *NSW Drug and Alcohol Withdrawal Clinical Practice Guidelines* (2008) which are currently under review, with special considerations including: concomitant illnesses; a potentially longer period of use/dependence; vulnerability if admitted to a unit with predominantly younger people; difficulties with mobility and increased risk of falls; communication issues (e.g. decreased hearing); and increased risk of delirium. Similar considerations are echoed in the *Model of Care Involuntary Drug and Alcohol Treatment Program Version 4*, which is underpinned by the *NSW Drug and Alcohol Treatment Act 2007*. Australian guidelines for treatment of alcohol disorders (8) also have specific guidelines relevant to older people.

9. The *National Guidelines for Medication-Assisted Treatment of Opioid Dependence* (2014) These new national guidelines note the ageing of patients in opioid substitution therapy (OST), which can be associated with increased likelihood of problems associated with accumulating factors from a drug-using lifestyle. It is noted that issues around long-term high doses of opioids can impact on the ageing process, such as osteoporosis and hormone deficiencies, as well as issues including reduced cognition, risk of falls, changes in pharmacokinetics and polypharmacy. Common associations highlighted in the older OST population include chronic hepatitis C, obesity and smoking-related issues. The Guidelines highlight the need for better coordination of care to address these multiple issues. More specifically regarding dosing regimes, the Guidelines report that despite a lack of direct evidence, older drug users are likely to metabolise drugs at a slower rate making lower opioid doses and slower dose titration of methadone advisable in older patients.

10. The *NSW Service Plan for Specialised Mental Health Services for Older People (SMHSOP)* 2005-2015 acknowledges the need for more work on the area, and coordinated responses regarding older people with drug and alcohol issues.

The South Australian Department for Health and Ageing on behalf of the Intergovernmental Committee on Drugs (IGCD) has commissioned Health Outcomes International to conduct a comprehensive process of stakeholder engagement to inform the development of and obtain demonstrated support for the *National Drug Strategy 2016-2021* (the ‘revised Strategy’); and develop an evidence based Draft Revised Strategy, designed to maximise health and social outcomes, ready to present for endorsement to Ministers by the end of 2015.

The following NSW guidelines are currently being reviewed:

1. *NSW Health Drug and Alcohol Plan 2006-2010*
2. *NSW Opioid Treatment Program – Clinical guidelines for methadone and buprenorphine treatment of opioid dependence* (2006) does not include a focus on older people. However, it is understood that the draft revised guidelines currently under development do so.

The Older People’s Drug and Alcohol Project has the ability to inform these plans and programs whilst in draft consultation phase.

Furthermore, older people’s drug and alcohol use is an area of growing interest and activity nationally. The National Centre for Education and Training on Addiction (NCETA) is initiating a national collaborative network, and some other states are producing work and initiating responses to the growing needs of older people with substance misuse issues. There is also a growing awareness of and work related to comorbidity of drug and alcohol and mental health issues, with a forum hosted in NSW in 2014. This work is relevant to this project context and may provide opportunities to align project recommendations with future comorbidity guidelines.

There are a number of key strategic directions at the national and state levels in ageing and aged care policy, drug and alcohol policy and mental health policy that are part of the project context and underpin its recommendations. In ageing and aged care policy, there is a significant focus on healthy, positive ageing and social inclusion, consumer directed care, and reablement (*NSW Ageing Strategy, 2012; Australian Government*...
Home Care Packages Programme Guidelines, 2014; and Commonwealth Home Support Programme: Good Practice Guide for Restorative Care Approaches (incorporating Wellness, and Reablement) (forthcoming)). National and state mental health policy promotes ‘recovery-oriented care’ (National framework for recovery-oriented mental health services; Living Well: A Strategic Plan for Mental Health in NSW 2014-2024; Fourth national mental health plan: An agenda for collaborative government action in mental health 2009-2014). National and state drug and alcohol policy emphasises a harm minimisation approach, incorporating the three pillars of demand reduction, supply reduction, and harm reduction (National Drug Strategy 2010-2015). These terms are defined in the glossary of this report. Within health and human services, person centred care and integrated care are important concepts that are very relevant to this project (NSW Health Integrated Care Strategy 2014-2017; ACI report Building Partnerships: a framework for integrating care for older people with complex health needs; The Health Foundation’s 2014 report Person centred care: from ideas to action).

Recognition of the roles and rights of carers is also relevant to this project, and is supported by both policy and legislation (National Carer Strategy and Carers Recognition Act, 2010).

Project methodology and scope

KEY POINTS: Project methodology and scope

The focus of the project is primarily on NSW Health drug and alcohol and mental health services.

The project approach involved use of an Expert Advisory Group; a review of the literature and current good practice examples, and wide stakeholder consultation; service utilisation data analysis, and development of this project report and recommendations.

The term ‘older people’ in this project generally refers to people aged 50+, acknowledging the broad nature of this age range, and the varying target age ranges in use by different sectors. The ‘younger old’ are from 50+ and are more likely to have continued heavy patterns of substance use from earlier ages of onset, and experience premature ageing-related health problems, and commonly also cognitive impairment and a range of other social issues. The ‘older old’ cohort refers to people from 65 years+, and includes people with a broader range of onset ages and instigators, and health status.

The project has been undertaken by older people’s mental health (OPMH) and drug and alcohol clinical policy teams in the NSW Ministry of Health Mental Health Drug and Alcohol Office (MHDADIO), and informed by consultation and advice from key stakeholders. An Expert Advisory Group (EAG) was formed to provide advice and guidance on the project and further oversight has been provided through existing mental health and drug and alcohol governance and advisory mechanisms.

The project approach has incorporated:

- A literature scan of local, national and international best practice and available evidence in relation to the delivery of drug and alcohol services to older people.
- Consultation with key drug and alcohol and mental health NSW Health committees and advisory groups, consumers and carers (where possible), and other key stakeholders to scope the needs of older people in relation to drug and alcohol service delivery and existing responses.
- Peak statewide and local consultation workshops, hosted by Local Health Districts and other organisations, with invitations extended to a broad cross section of stakeholders. A table of stakeholders consulted is tabled at Appendix E: Consultation Details.
- Documenting access to and appropriateness of key existing NSW service models, service responses and best practice examples (including supported accommodation models and partnerships with other sectors) within drug and alcohol and OPMH and across the spectrum of care.
- Reviewing service access data and other relevant service access and utilisation information, where available, for older people with substance use issues accessing drug and alcohol and mental health services. This data is included in this report at section 3A.
- Identifying the emerging needs of older people within existing drug and alcohol and mental health programs, such as the NSW Opioid Treatment Program and other relevant services and programs.
Identifying key elements of coordinated and integrated care for the population group.

Exploratory analysis of the service models, service responses and service development opportunities which may be appropriate for the target group.

Preparation of this project report, including recommendations regarding key opportunities to improve responses to the needs of older people with drug and alcohol issues through service development and service improvement, with the aim of supporting capacity building to deliver appropriate responses.

Consultation has been undertaken via mixed methodology, with a set of workshops carried out in June 2014, and phone interviews carried out in July and August 2014. Key committees have been consulted in the planning and scoping of this project and at key points, and through review of the project report. The consultation workshops included four hosted by Local Health Districts (LHDs), a workshop for peak organisations hosted by the Network of Alcohol and Other Drugs Agencies (NADA), and a workshop hosted by the Inner City Health Networks NGO Partnership Network at St Vincent’s Hospital. The LHD workshops were hosted by:

- Central Coast LHD: SMHSOP, Gosford Hospital; with invitations extended to Northern Sydney LHD stakeholders
- Western Sydney LHD: Drug Health, Westmead Hospital; with invitations extended to South West Sydney and Nepean Blue Mountains LHD stakeholders
- Western NSW LHD: SMHSOP, Bloomfield Hospital, Orange
- Mid North Coast LHD: Drug and alcohol, Coffs Harbour; with invitations extended to Northern NSW LHD stakeholders.

Invitations to workshops were sent officially to hosts by MHDAO, with host services asked to distribute invitations more widely to local stakeholders. Identified stakeholders for invitation by hosts included clinicians and managers from drug and alcohol services, older people’s mental health services, adult mental health services, aged health services, emergency services, and mental health and drug and alcohol non-government organisations (NGOs), general practitioners (GPs) and/or Medicare Locals (as they were known at the time – now Primary Health Networks), consumer and carer organisations, Aboriginal Drug and Alcohol Network (ADAN) and/or Aboriginal Medical Service representatives, and multicultural health services.

Multidisciplinary representation, including allied health, was requested, and workshops were planned to encourage attendance and responses from people across metropolitan, regional and rural areas.

Consultation interviews were carried out with particular stakeholder groups, and key informants/priority stakeholders unable to attend workshops. Interviews were carried out with the following stakeholders: Pharmacy Guild of NSW, NSW Office of the Public Guardian, NCETA, Justice Health and Forensic Health Network, NPS MedicineWise, and the Aboriginal Health and Medical Research Council (AH&MRC).

In addition, key NSW Health committees and advisory groups have been consulted in the planning and scoping of this project and at key points, including reviewing and providing feedback on the project report. These committees include the NSW Drug and Alcohol Program Council, the Mental Health Program Council, SMHSOP Advisory Group, Mental Health Clinical Advisory Council, Drug and Alcohol Quality in Treatment Advisory Group, Mental Health Consumer Subcommittee, Aboriginal committees/working groups, and CALD committees/working groups. An earlier working draft of the project report was reviewed by and feedback received from key ACI network chairs, including the aged health, allied health and nursing networks.

In summary, stakeholders consulted using the varying methods included the following groups:

- peak drug and alcohol consumer and carer organisations, and an adult aged consumer of drug and alcohol services
- a peak mental health carer organisation, and carers of people with mental illness
- drug and alcohol managers, clinical leaders and clinicians from major city areas, and inner and outer regional areas. One coordinator also had responsibility for remote areas.
- SMHSOP managers and clinicians from major city areas, inner and outer regional areas. One coordinator also had responsibility for remote areas.
- adult mental health services from major city areas and inner regional areas
- aged health clinicians
- emergency department management and clinicians
- primary care sector representation (from Medicare Locals)
- drug and alcohol NGOs, including residential rehabilitation services
residential aged care facilities, and an aged care peak body
Aboriginal drug and alcohol network
Aboriginal health services
multicultural health services and organisations, and
researchers.

Limitations
A significant limitation in project processes has been the difficulty of achieving consumer consultation. Whilst mental health and drug and alcohol consumer and carer organisations were consulted, not all of those organisations necessarily feel equipped to comment on older people’s drug and alcohol issues, and as such there was limited consultation with older people with drug and alcohol issues or their representatives. There is a range of contributing factors, including the limited history of consumer engagement in the drug and alcohol sector, as well as those factors central to the consultation themes – recognition and engagement of the target group are low and stigma levels are high, and current provision of services to older people with drug and alcohol issues is relatively low. The outcome of this is that there are not established processes, relationships or services to draw on to access consumers for consultation. Notwithstanding this limitation in the project processes, other Australian research incorporating older adults’ viewpoints has been used to inform the project report (Australian Injecting and Illicit Drug Users League (AIVL), 2011; Draper, 2013; Fink, Beck & Wittrock, 2001; Wilkinson, 2008).

Further work regarding older people and substance misuse will need to consider strategies for greater consumer participation and engagement regarding older people with drug and alcohol issues, as part of the further development of consumer engagement across the NSW drug and alcohol and mental health programs.

Scope of the project
The following have been taken as in-scope:

1. Demography (age, sex, place of residence) and epidemiology (health statistics)
2. Needs of older people in relation to drug and alcohol screening, assessment and treatment within drug and alcohol services and mental health services
3. Existing service models/models of care for the target group, including supported accommodation models, the Involuntary Drug and Alcohol Treatment Program (IDAT) and the NSW Opioid Treatment Program (OTP)
4. Service utilisation (where data is available)
5. Existing literature and best practice regarding drug and alcohol services and service responses for older people, including population based planning models
6. Older people with co-morbid drug and alcohol and mental health issues.

The project focus is on NSW drug and alcohol and mental health services. However, some broader strategic and service interface issues have also been highlighted, and are included in this report and recommendations.

In addition to the project scope as listed above, there has been considerable discussion in project processes regarding scope of the work and of the definition of the project’s target population. The agreed target group definition developed in consultation with the Expert Advisory Group, and broadly supported in consultation processes, is people aged 50 years and over, including those who are at risk of developing a substance use disorder at the age of 50 years and over, or those who have a long standing substance use disorder.

Within this large age range, two primary cohorts emerged, referred to as the ‘younger old’ and the ‘older old’. ‘Younger old’ broadly refers to younger people from the age of 50 experiencing premature ageing-related functional and physical decline associated with long standing substance misuse. This may include complex morbidity issues including dementia or acquired cognitive impairment. This cohort is distinct from people aged 50+ who are not experiencing ageing-related issues, and are appropriately seen in adult services. ‘Older old’ refers to those aged 65 and over who may experience a range of ages of onset and current health status. Aboriginal people are considered in scope for the purposes of the project from 50 years of age, in line with national aged care planning processes.

Another way to conceptualise the range of issues and cohorts is put forward by Nicholas & Roche (2014b): maintainers, survivors and reactors. Maintainers continue their previously unproblematic use until older ages, at which point normal ageing processes may start resulting in harms. Survivors are early onset users or ‘problem drinkers’ whose use persists into older age, often accompanied by comorbidities; and reactors are late onset users whose problems begin in their 50s or 60s, often in relation to stressful life events (Nicholas & Roche, 2014b).
The complexities of varying target ages for services are also noted, with a number of issues considered in defining the target group for this project. Firstly, while age is not generally used as an eligibility or exclusion criteria for aged care services, a range of aged care services and programs, including SMHSOP, are generally targeted to people aged 65 years or 70 years and over. Nevertheless, because these services specialise in age-related health care and support, they generally cater to some extent (depending on their capacity and prioritisation processes) to ‘younger old’ people who require assessment, care and support associated with their functional disabilities. This approach informs this project. Secondly, for aged care planning purposes, the need for community and residential aged care services is assessed in relation to the population of people aged 70 years and over (broadly in line with the older cohort for the project noted above).

Case study 1: The ‘younger old’, and complex care needs

Case study exemplar: ‘Mr S’

Mr S was a younger man with significant geriatric syndromes and progressive neurological decline. He had a long-standing history of cannabis, tobacco and alcohol use, and other illicit substances as well from adult ages. His current care needs related to his head injuries, intellectual disability, neuropathic pain, cardiovascular issues, major depressive disorder, and severely aggressive panic disorder.

Mr S had been living in an isolated situation and was hospitalised after an ischaemic brain event, with severe malnutrition, dehydration, and withdrawal symptoms. He was hospitalised for an extended amount of time awaiting medical stability and suitable care and accommodation options.

Whilst in hospital this man had aggressive incidents requiring the involvement of police, resulting in him requiring a private security guard 24/7. Due to his aggressive issues he was deemed too high risk to be placed into the local behavioural unit, due to frailty of other patients.

Drug and alcohol services were involved during the period of hospitalisation. There was a significant lack of understanding on the geriatric medical service’s behalf about multiple substance dependence and withdrawal, and a lack of understanding on the drug and alcohol service’s behalf about geriatric issues when working through withdrawal regimes for Mr S.

Different care arrangements were trialled with this patient, and a person centred and holistic approach revealed learnings regarding his behavioural needs and triggers.

Finding suitable placement options for Mr S was difficult. His younger age made accessing assessment difficult initially, and many facilities rejected the application on the basis of risk, without carrying out a face to face assessment. Some services rejected applications on the basis that after a lengthy period of detox his functioning might change, but opinions differed in how long detox would take and how much his function was likely to change. In the end placement was found in a very unlikely option – a regular Residential Aged Care Facility with service manager who has an interest in placing people with a history of substance abuse. The service requested some trials such as a move into a 4 bed ward before carrying out a face to face assessment, and accepting the referral for what was ultimately a successful placement (through utilising a number of harm minimisation and psychosocial strategies).
Case study exemplar: ‘Mrs B’

Mrs B was a 75 year old widow living alone since the death of her son two years previously. She had a history of presentations to the emergency department with falls, but her alcohol abuse went unrecognised. Mrs B was malodorous but reported showering regularly, and refused a homecare package. It is thought she was drinking up to one bottle of scotch a day during this time.

Mrs B then presented twice with suicide attempts while intoxicated and was admitted to the acute inpatient mental health unit for older people on both occasions as an involuntary patient. Within several days Mrs B denied all symptoms of depression and minimised her alcohol intake. She did not appear depressed but had persistent mild cognitive impairment, mainly frontal, and memory impairments. Mrs B did not want follow up with either the mental health or the drug and alcohol service, but accepted follow up visits from the mental health team. The local drug and alcohol service were not able to see her at home in the community and required that she attend outpatient visits at the hospital, which she would not agree to. Mrs B continued to deteriorate despite assertive follow up from the mental health service and was financially exploited by a neighbour, losing $20,000. Her driver’s licence was cancelled after an incident in a car park while intoxicated. She was not breath tested by police as they were under the impression that she was confused due to a medical condition.

Mrs B was eventually placed in a residential aged care facility after a Public Guardian was appointed to make decisions about her accommodation and care. The risks associated with exploitation were managed in conjunction with the Guardian. The Guardian also prevented her transfer to other, less appropriate, care. SMHSOP services provided support and advice for her GP and facility staff at times, including when it was felt that her placement there was inappropriate and unsustainable. The majority of Mrs B’s multiple presenting problems, including depressive symptoms, behavioural problems and suicide attempts resolved with cessation of her alcohol use.

Definitions

A glossary has been included at the front of this report, in an attempt to clarify the numerous terms that have variable uses in the drug and alcohol, mental health and aged care sectors, and in policy and literature. Of note, the terms ‘recovery’, ‘specialist services’, and ‘early/late onset’ can have very different meanings for different audiences and are included in the glossary as used in this report.
The four main substance groups in the context of this project are alcohol, illicit drugs, misuse of pharmaceuticals, and tobacco.

**Alcohol**

**KEY MESSAGES: Alcohol**

As with younger adults, alcohol can play an important role in social engagement for older people.

Older people in Australia are less likely to binge drink, but are the most likely age groups to be daily drinkers.

The negative health effects of alcohol increase with age, in addition to age-specific potential harms such as increased medication interactions and risk of falls and social isolation.

There are no safe drinking guidelines for older people in Australia. International guidelines vary but rarely support more than one standard drink per day.

Alcohol is the most common drug used by older people (Australian Institute of Health and Welfare (AIHW), 2011 & 2014b; Spencer, 2001). In the US, Blazer and Wu (2011) found that 14% of men and 8% of women reported at-risk drinking, and that alcohol misuse was a marker for other problems, such as illicit drug use, tobacco use and misuse of prescription medications (Blazer & Wu, 2011). Whilst drinking among younger populations is often very public, alcohol use among those over 65 is often undertaken in private and attracts little media attention (Dare, Wilkinson, Allsop, Waters & McHale, 2014).

The 2010 Australian National Drug Strategy Household Survey found that high-risk drinking for alcohol-related harm from disease or injury occurred in 15.3% of people aged 65 to 74 years and 9.4% of people aged over 75 years living in the community (AIHW, 2011). Daily drinking is higher among older Australians than younger Australians, with both males and females over 70 the highest age group for daily drinking, but also the lowest rates for consuming alcohol in risky quantities (AIHW, 2014b). In patients in hospital and community geriatric and older people’s mental health services, it was found that 16.2% aged 60 years and over had high risk drinking for alcohol-related harm (Draper et al, 2015).

Data from www.healthstats.nsw.gov.au indicates 2011 estimates of alcohol consumption at levels of risk to health for people aged 65-74 years at 15.6% (consistent with the national household survey data above), and people aged 75 and over at 7.6%, with males at higher prevalence rates than females in both age groups. This is supported in the international literature, such as that from the US where alcohol problems are more significant among older males than older females (Wang & Adnrade, 2013).

Australian data from the Australian Bureau of Statistics indicates an increasing prevalence of at risk drinking among people aged 65 and over as per Figure 1.

**Figure 1:** Consumption of alcohol in quantities at a risk or high risk to health in long-term in Australia by age, 2001, 2004-05 and 2007-08 (ABS, 2012)

<table>
<thead>
<tr>
<th></th>
<th>2001</th>
<th>2004-05</th>
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<tr>
<td></td>
<td>Males</td>
<td>Females</td>
<td>Males</td>
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<tr>
<td>65+ years</td>
<td>7.4%</td>
<td>5.9%</td>
<td>8.8%</td>
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For these estimates, risky drinking is defined as drinking more than 2 standard drinks on any day when drinking alcohol.
In the literature, high-risk alcohol users were found to be more often male (2 – 5 times more likely), live in social environments where alcohol is not condemned, have higher education levels, smoke more often and be more often single or depressed, and possibly have poorer cognitive function (Aartsen, 2011).

Shaw & Palattiyil (2008) have described significantly different patterns of alcohol abuse in older people when compared with younger age groups. One third of older adults with alcohol use disorders develop these in later life (RCPsych, 2011). Late onset occurs more commonly when an older person is coping with changing life circumstances such as bereavement, mental health problems and physical health problems (Kist et al, 2014; Shaw & Palattiyil, 2008). Other triggers may include loneliness and social isolation, loss of occupation or income, disability or decline in functioning, boredom, anxiety, insomnia, family conflict, low self-esteem, sensory deficits, poor mobility and cognitive impairment (Taylor, Jones & Dening, 2014).

Some research has found a decrease in consumption with increasing age, which may be because older adults with more health problems tend to curtail their alcohol consumption (Christensen, Low & Anstey, 2006). Other research has also found that problem drinkers reported more severe pain, and the use of alcohol to manage pain (Christensen, Low & Anstey, 2006; Gilson, Bryant & Judd, 2014).

Types of alcohol abuse is often broadly defined into two categories, late and early onset. In the literature, early onset is considered to be where a person has been a heavy drinker and is addicted to alcohol before the age of 25 (Aartsen, 2011; Kist et al, 2014; Kok, 2014). It is worthwhile to note this definition of late onset is when problem drinking commences after the age of 25, whereas in practice and in the context of this project late onset is generally used to describe onset as an older adult. It is probably useful to describe a third category of very late onset, for those whose problem drinking commences after the age of 45 (Kist et al, 2014; Aartsen, 2011). One study has identified that approximately one third of older people with alcohol abuse problems commence in late life (Pierucci-Lagha, 2003). Antisocial personality is found to be frequently associated with early onset (Aartsen, 2011) and late onset (after age 25) is often observed in people who are homeless, have family members with alcohol problems and have low socioeconomic status.

There is a dearth of research on people who start drinking heavily at older ages, but it has been observed that this cohort often demonstrate better social functioning, family lives and professional careers (Aartsen, 2011). Late (or very late) onset users often begin using because of stressful life events, including retirement, marital breakdown, social isolation or bereavement (European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), 2008).

As people age, physiological changes impact tolerance to alcohol, including a higher sensitivity and decreased ability to metabolize alcohol. Older people are more likely to drink on a daily basis than any other demographic (AIHW, 2011), and many drink more than the levels that are generally recommended by health agencies (Wilkinson, Allsop & Chikritzhs, 2011). Older people are also at increased risk of experiencing alcohol-related harm due to physiological changes associated with the natural ageing process (WHO, 2014). One study found that a significantly larger proportion of the at-risk drinking group relative to the non-risk group admitted falling or injuring themselves (5.3% vs. 0.7%) or forgot to take medications because of the use of alcohol (Immonen, Valvanne & Pitkala, 2011). Additionally, light to moderate alcohol intake can interact with many medication commonly taken by older people (Fink, Beck & Wittrock, 2001), as discussed further in the medications section.

Social engagement and socialisation are complex in relation to older people’s alcohol use. Across the age ranges, alcohol use is associated with social engagement. This becomes more complex in later life when social roles can change and isolation is higher risk (Wilkinson & Dare, 2014). Social engagement, or a lack of, also plays a role in alcohol misuse or disorders (Spencer, 2001). Johnco, Draper and Withall’s 2015 literature review reported that older men with heavy drinking patterns are more likely to be divorced/separated, have lower perceived family/friend support, and are less likely to be socially engaged (Johnco, Draper & Withall, 2015). It is likely that some socially disengaged men use alcohol to cope with depressive symptoms, while in others increased drinking precipitates social disengagement. Many older adults report self-medicating motivations for engaging in alcohol consumption, including drinking to reduce pain, because of a meaningless life, anxiety, depression, loneliness and sleep problems (Aira, Hartikainen & Sulkava, 2005; Johnco et al, 2015). Among people aged over 91 years, the most common reason for using alcohol was for medicinal reasons (Immonen, Valvanne & Pitkala, 2011). Self-medicating motivations and positive alcohol expectations such as believing alcohol will improve mood, are associated with an increased risk of drinking problems (Johnco et al, 2015).
Alcohol abuse is associated with a range of adverse health risks and outcomes in addition to the unique risks drinking presents for older people. Health risks for older people associated with alcohol abuse include falls, compromised mobility, decreasing cognitive ability, motor vehicle crashes and suicides; in addition to the many comorbidities and significant health problems associated with alcohol abuse in later life, including increased risk of hypertension, stroke, cardiopulmonary disease, gastrointestinal disorders, peptic ulcers/oesophageal reflux, diabetes, chronic obstructive pulmonary disease (COPD), Wernicke-Korsakoff Syndrome (WKS), liver cirrhosis, cancers, delirium, dementia, and depression (Holmwood, 2011; Johnco et al, 2015; Spencer, 2001). One study looking at health profiles of an outreach treatment program cohort found that the majority of clients had three or more significant health problems (Spencer, 2001).

Alcohol abuse can cause cognitive impairment. The term Alcohol Related Dementia (ARD) is often used interchangeably with Alcohol Related Brain Damage (ARBD), to include WKS, Amnestic Syndrome and Front Lobe Syndrome (Draper, 2012). WKS prevalence is around 1-2% in the general population and 12-14% in the population abusing alcohol. There is an increasing prevalence of ARBD internationally (RCPsych, 2014). ARD is relevant in 5 to 10% of younger onset dementia with an average age of onset found in one study to be 52 years (Ridley, Draper & Withall, 2013).

It is important to note that the relationship between alcohol consumption and poor health outcomes is not straightforward (Christensen, Low & Anstey, 2006), and there is a U-shaped relationship between the amount of alcohol use and health: moderate alcohol users are healthier than high-risk users and abstainers (Aartsen, 2011; Reid et al, 2002). Moderate consumption of alcohol has beneficial effects on physical and mental health in general (Aartsen, 2011; Christensen et al, 2006) and light or moderate alcohol consumption has different risks and benefits for older people compared with younger people. Observational research has demonstrated older adults who drink moderately have better cognitive functioning, lower rates of cardiovascular disease, and longer life expectancy than people who do not drink (Duru et al, 2010; Reid et al, 2002). Harmful/disordered use is, however, associated with a multitude of negative effects as outlined above. Adding to this complexity are the findings that indicate that social engagement can have a protective effect on cognitive impairment and dementia, and alcohol’s role in socialisation in older people (Wilkinson & Dare, 2014). There are unclear messages about alcohol use in late life and a difficult balance between potential benefit and potential harms (RCPsych, 2011). This balance is still contentious, notwithstanding recently published research that reports previous associations of a protective effect between alcohol intake and all cause mortality may have been partially related to issues with research methodology and poor adjustment for confounders (Knott, Coombs, Stamatakis & Biddulph, 2015).

Consulted stakeholders provided insights relevant to older people and alcohol use, in particular the under-recognition of problems, and ageism/therapeutic nihilism regarding early onset/lifelong drinkers. Views such as drinking being ‘the last pleasure left in life’ can be present, and can combine with or support nihilistic views.

Stakeholders noted that socially isolated people in the ‘older old’ cohort may tend to use alcohol at home, without causing a disturbance to others and therefore are not identified as having issues as readily. Issues related to life stage transition and major life changes experienced by older people such as retirement, grief and loss, and divorce, can all impact on alcohol use and access to services. Stakeholders noted that some older people function well whilst working and using alcohol, and then decline rapidly on retirement, whilst others gradually increase alcohol use post-retirement to risky levels. The increase in divorce rates is likely to also impact on managing life stage transitions, socialising and using alcohol at older ages.

As highlighted by Wilkinson (2008), balancing harm reduction, health, and quality of life is key to formulating policy in the field of alcohol and ageing.

Guidelines for alcohol consumption

Alcohol guidelines, such as the Australian Guidelines to Reduce Health Risks from Drinking Alcohol do not provide specific guidance relevant to late life. However, it is noted that:

light to moderate alcohol consumption in older adults may lower the risk of several chronic conditions. However, for some older adults, drinking alcohol increases the risk of falls and injuries, as well as some chronic conditions. Older people are advised to consult their health professionals about the most appropriate drinking levels for their health (National Health and Medical Research Council, 2009, pp. 88).
Guidance or recommendations from the US and the UK vary, as do definitions of standard drinks or units of alcohol. However, one area of consensus appears to be advising against more than approximately one alcoholic beverage per day, with varying definitions of 'bingeing' (Christen et al, 2006; Mukamal, Massaro & Ault, 2005; RCPsych, 2011; Wang & Adnrade, 2013). Most guidelines and health promotion materials do not address non-hazardous drinking or key elements of concern for older people such as the relationship between alcohol consumption and physical and mental health, medication use, and functional status (Fink et al, 2001).

Illicit drugs

KEY MESSAGES: Illicit Drugs

The number of older people using illicit drugs has historically been low. However, it is considered that the ageing “baby boomer” population will present increasing numbers of older people with illicit substance misuse issues and a range of new challenges for services.

Illicit drug use can have negative impacts on health status, quality of life, and on family and social relationships that accumulate with age, and the long term cognitive effects of illicit substances are largely unknown.

Existing treatment populations, such as the clients of the Opioid Treatment Program, are ageing, and experiencing ageing-related issues that the services are ill-equipped to manage.

A small percentage of older people use illegal drugs. However, studies indicate that this is expected to increase with the ageing of the baby boomer cohort (Wang & Adnrade, 2013; Gfroerer et al, 2003). Data available from US studies found that for older people, the primary problem substance was alcohol (76.3%), followed by heroin and other opiates (14.3%), cocaine (5.4%) and marijuana (1.4%) (Christensen et al, 2006; Arndt, Gunter, & Acion, 2005). The AIHW National Drug Strategy Household Survey (2014) found that in NSW, 6% of people who reported a recent use of an illicit drug were aged over 60, which represents a 1.5% increase from the previous survey. In the previous report, 7.4% of Australians aged 65 to 74 had used an illicit drug in their lifetime (AIHW, 2011). Of note, in the most recent AIHW National Household Survey Report people aged over 50 showed the highest rise in illicit use of drugs and were the only age groups to show a statistically significant increase in use in the most recent survey, mainly due to an increase in the use of cannabis (AIHW, 2014b). The rates of use of cannabis in people aged 50 to 59 and in those aged 60 or older are at the highest levels recorded in the past decade of the survey (AIHW, 2014b). Whilst the proportions are still lower than younger age ranges, the ageing cohort of cannabis users was demonstrated with males aged 60 or older twice as likely to use cannabis in 2013 compared to 2010 (0.8% to 1.8%), and females aged 50-59 1.6 times as likely to use cannabis (from 3.2% to 5.2%) (AIHW, 2014).

Long term substance use can impact on people’s health, with cardiovascular, hepatic, respiratory, endocrine, psychiatric, cognitive and immune function all reported to be negatively impacted by chronic use (Lintzeris et al, 2015). The long term cognitive effects of illicit substance use are largely unknown, although it is well established that drug use can have negative impacts on health status, quality of life, and on family and social relationships, and these impacts can accumulate with age (Johncote et al, 2015). Additionally, a recently published paper examining the effects of cannabis use shows significant adverse effects from long term use (Hall, 2014).
2014), in addition to previous studies indicating higher rates of cognitive impairment in frequent and/or long term cannabis users (Hall & Degenhardt, 2014). Hall & Degenhardt summarise the most probable negative health effects of chronic cannabis smoking as: cannabis dependence; chronic bronchitis; psychotic symptoms; residual cognitive impairment for up to a month after abstinence; and cognitive impairment in those who initiate early and use daily for at least a decade (Hall & Degenhardt, 2014). There is still much that is unknown concerning longer term use specifically into older age, and significant physical comorbidities.

There are limited screening or assessment instruments available for identifying or diagnosing illicit drug abuse in the older population (Simoni-Wastila, 2006). Validated screening tools often have not been validated in the older population. The ASSIST (Alcohol, Smoking and Substance Involvement Screening Test) screening tool (discussed further in Screening and assessment section from page 73) has been used in pilot programs for older people in NSW but has not been formally evaluated or validated in older populations.

Ageing treatment populations

In addition to the current and anticipated generational changes going forward, many longer term clients of drug and alcohol programs, particularly those accessing Opioid Pharmacotherapy Treatment (OPT), are ageing (AIHW, 2011, 2014c, and 2015). There are several national surveys demonstrating the growing proportion of older opioid users and a trend towards ageing (Australian Injecting and Illicit Drug Users League (AIVL), 2011). The National Opioid Pharmacotherapy Statistics 2013 (AIHW, 2014c) demonstrate opioid pharmacotherapy clients are getting older on average, as depicted in Figure 2. In 2013, around two-thirds (69%) of clients were aged 30-49, and this proportion has been fairly consistent since 2006. However, from 2006–2013 the proportion of clients aged less than 30 more than halved (from 28% to 11%), and the proportion of clients aged 50 and over more than doubled (from 8% to 19%). These trends suggest an ageing population of clients in pharmacotherapy treatment. The trend has continued with the 2014 statistics demonstrating the proportion of OTP clients aged 50 years and over has risen to 21%. On a snapshot day in June 2014, the total number of Australians on a course of pharmacotherapy treatment for their opioid dependence was over 48,000 (AIHW, 2015); this indicates over 10,000 clients aged 50 and over across Australia. Opioid death rates in Australia increased from 15 per million to 30 per million between 2001 and 2005 (Holmwood, 2011) in older age groups.

In 2013, clients ranged in age from their mid-teens to their late-80s. The median age of clients across all pharmacotherapy types was 40 years, compared with 39 in 2012 and 38 in 2011 (the first year these data were reported). At a state and territory level, there are between 19,000 and 20,000 people in the OTP in NSW on a snapshot day. Clients in New South Wales and South Australia had the oldest median age (41 years).

Figure 2: Clients receiving pharmacotherapy on a snapshot day, by age group, 2006–2013 (source: National Opioid Pharmacotherapy Statistics (NOPSAD) report, AIHW 2014)
As opiate-addicted people age, the health problems they experience such as high rates of cardiovascular disease and diminished executive functioning can be exacerbated by age-related illness, social isolation and general physical decline, and thus may require specialised medical approaches (Rosen, Smith & Reynolds, 2008). Mortality in drug users can be between 12 and 22 times that of the general population, and older addicts are between two and six times more likely to die than younger ones (Crome, Sidhu, & Crome, 2009). A NSW study of people accessing drug and alcohol services (approximately two-thirds OST clients) found the majority of participants experienced social isolation and/or disadvantage, with only 6% in a current relationship, and 7% employed in any capacity (Lintzeris et al, 2015).

Additionally, this study found that older OST participants were more likely to have drunk alcohol, and on more days, than younger OST participants; and that a greater proportion of older OST participants had used benzodiazepines than the younger OST participants (Lintzeris et al, 2015).

There is an increasing average age of people using the Needle and Syringe Program in Australia, with 9% of the program’s users aged 50 years or over (AIHW, 2011). The following figure (3) demonstrates the numbers of visits to the Sydney Medically Supervised Injecting Centre (MSIC), by age group (noting individual clients make multiple visits each year). It shows a decreasing proportion of visits by those aged 0-49 since 2002, with an increasing proportion in the 50-59 cohort and also an increase for those aged 60-64 since 2007. The emergence of a 65+ cohort from 2012 indicates an ageing cohort of injecting drug users in this community.

In the consultation processes, stakeholders concurred with the themes arising in the literature, particularly regarding the ageing of the treatment population, noting that current rates of overdose are lower than historically, which has resulted in substance abusing populations living to older ages and as such experiencing ageing-related issues for the first time. The Australian Injecting and Illicit Drug Users League (AIVL) 2011 discussion paper highlights that among the older injecting opioid users, health is a key concern for the future, in addition to financial, employment and family issues (AIVL, 2011).

**Figure 3: MSIC Visits in NSW by age group from 2002-2013**
Key Messages: Medication Misuse

Misuse of prescription drugs among older adults can range from sharing medications and using medications at higher dosages or for longer periods of time than prescribed, to persistent abuse and dependency issues. The two main classes of medications that present a concern for abuse are the benzodiazepine sedative-hypnotics and the opioid analgesics.

Data from the Sydney MSIC demonstrates an increase in older people presenting to the service overall, and specifically presentations for pharmaceuticals have shown a significant increase since 2007.

Misuse of prescription drugs among older people can range from sharing medications and using medications at higher dosages or for longer periods of time than prescribed, to persistent abuse and dependency issues. The two main classes of medications that present a concern for abuse are the benzodiazepine sedative-hypnotics and the opioid analgesics.

The Australian National Drug Strategy Household Survey (2010) found that 3.6% of people aged 65-74 years, and 6.1% of people aged over 75 years used pharmaceuticals for non-medical purposes in the preceding 12 months, while 4.9% of people aged 65-74, and 7.3% of people aged over 75 years had a lifetime use of pharmaceuticals for non-medical purposes (AIHW, 2011). In the US it has been reported women without social support are most likely to use prescription drugs inappropriately, and that older people may use pharmaceuticals to cope with ageing-specific stressful life events (Wang & Adnrade, 2013).

Other older people may take medications as prescribed, whilst not disclosing alcohol use. Even at low levels of alcohol consumption, medication interactions occur. Fink, Beck and Wittock (2001) summarise the types of medications commonly taken by older people that have interactions with alcohol: medications for peptic ulcer disease; aspirin and non-steroidal anti-inflammatory; benzodiazepines; narcotics; antihistamines; tricyclic antidepressants; oral hypoglycemics; and aldomet, nitroglycerin, or hydralazine (Fink et al, 2001). A NSW study of older drug and alcohol service users found a high proportion of older OST clients reported alcohol and benzodiazepine (prescribed or illicit) use (Lintzeris et al, 2015).

Data received from the Sydney MSIC on presentations in 2013 highlights the extent of the misuse of pharmaceuticals, and how this has changed over the past decade. Figure 4 represents a steady decrease in the proportion of presentations for heroin use over the ten year period to 2013, with pharmaceuticals showing a large increase since 2007. Presentations for cocaine and methamphetamines have remained steady over the period.

Figure 4: MSIC presentations by drug type (category) for those aged 50+ over the period 2002-2013
Data represented in Figure 4 is further broken down into specific drug types in the below graph (Figure 5). The data reflects heroin numbers remaining stable, with oxycodone being the most common drug type presentation, having increased in numbers significantly since 2007.

Although there is not yet clear evidence, the misuse of psychotics is an emerging trend within the misuse of pharmaceuticals, with quetiapine being of particular concern.

In addition to the misuse of pharmaceuticals, there have been a range of pharmaceutical use and prescription issues highlighted. Despite being out of scope for this project, and not a focus of drug and alcohol services, it is important to note how these issues can impact on older people and on the misuse of medications by older people. These issues are outlined in the following paragraphs, and included within the subsections below regarding benzodiazepines and opioid analgesics.

Medication use is high in older populations, with a 2010 Australian study estimating that 25% of older people are consuming up to five different prescription medications concomitantly (Hunter & Lubman, 2010), and the National Pharmaceutical Drug Misuse Framework for Action 2012-2015 reporting that approximately two-thirds of Australians over the age of 60 years regularly use four or more drugs. There are interaction risks associated with prescription and over the counter (OTC) medication use. Epidemiological studies suggest high rates of antipsychotic, antidepressant and anxiolytic and sedative-hypnotic drug use among Australians, with higher rates of use in those of 60 years of age and the highest rate of use in those aged 85 to 95 years (Holingworth et al, 2011).

Although sleep problems are more common in later life, the use of anxiolytic, hypnotic and sedative drugs is 500% higher in older people than in the general adult population (Australian Government, 2013). The prevalence of benzodiazepine use in older people remains high despite recommendations around avoiding prescribing these medications for insomnia, agitation or delirium in older people. Opioids have a role related to pain and distress in dementia, although there are contraindications and potential harms. There is strong evidence that benzodiazepines, antidepressants, and antipsychotics increase the risk of falls and serious injury for older people. Furthermore, antipsychotic medications are associated with increased mortality in older adults with dementia, and this risk increases with dose (Maust et al, 2015).

Figure 5: MSIC presentations by drug type (breakdown) for those aged 50+ over the period 2002-2013
**Benzodiazepines**

Studies have found that 23.3% of patients presenting to hospital emergency departments over 65 years used benzodiazepines (Christensen et al, 2006), 19.8% used stimulants, 14.4% used opioids, 9.6% used barbiturates, 7.9% used alcohol, 2.2% used phencyline and 0.1% used marijuana (Christensen et al, 2006; Rockett, Putnam, Jia, & Smith, 2006).

Evidence about the long terms effects of benzodiazepines on cognition, while mixed, suggests increasing risk of cognitive impairment and dementia. One Australian study has found that 27% of subjects (people over 60 in aged care or older people’s mental health services) were using sedatives as prescribed, and 3.3% were using sedatives in a non-medical way (Draper et al, 2015).

The prevalence of benzodiazepine use in older people remains high, despite recommendations around avoiding prescribing these medications for insomnia, agitation or delirium in older people (Gould, Coulson, Patel, Highton-Williamson, & Howard, 2014). Benzodiazepine use is a consistently reported risk factor for falls and fractures in older people, both after a new prescription and over the long term. These drugs affect cognition, gait and balance (ACSQHC, 2009). Inappropriate prescribing of benzodiazepines and other psychotropic drugs is estimated to occur in around 25% of people aged over 65 years (Holmwood, 2011). Rates of benzodiazepine use may continue to be high due to a lack of specialist knowledge about prescribing in geriatric care; difficulties in translating prescribing guidelines into practice; a perceived lack of priority for physicians due to the physical health needs of the patient; and physiological and psychological dependency (Gould et al, 2014). A meta-analysis of randomised controlled trials conducted by Gould et al (2014) found that in the short term, the odds of not using benzodiazepine were significantly higher for withdrawal with psychotherapy in comparison with control interventions (Gould et al, 2014). These beneficial effects of supervised withdrawal with psychotherapy were maintained at 12 months follow-up (noting that 95% prediction intervals suggested that this might not always be effective in individual settings at these two follow-up points).

No conclusions can be drawn regarding the effectiveness of withdrawal with prescribing intervention in the long-term (Gould et al, 2014). While there is evidence that the odds of not using benzodiazepines were significantly higher for a withdrawal with a prescribing intervention in comparison with control interventions in the short term, this needs to be interpreted with caution due to the small number of available studies (Gould et al, 2014). Although the magnitude of effect was small, there was evidence that multifaceted interventions aimed at changing prescribing were effective at significantly increasing the odds of not using benzodiazepines in comparison with control intervention in the short term (Gould et al, 2014).

**Case vignette 1: Benzodiazepine dependence**

**Case vignette: ‘Mrs H’**

Mrs H was an 83 year old female who lived with her husband, who also experienced worsening health. Mrs H had a long history of seeing many psychologists and psychiatrists, with diagnoses at varying times including different types of depression, anxiety disorder, cognitive impairment and benzodiazepine dependence. She had poor tolerance for psychotropic drugs.

Mrs H had been benzodiazepine dependent for more than 20 years, with previous alcohol intake approximately 4-5 nips of spirits daily; at this time up to 2 standard drinks daily. Her recent history included panic attacks and anxiety disorder with somatic symptoms; temporomandibular joint dysfunction and associated pain, and benzodiazepine dependence; with multiple presentations.

Mrs H required holistic management including supervised benzodiazepine withdrawal, supported by pharmacotherapy; psychotherapy; family therapy and support; engagement in social groups, and community aged care psychiatry contact.
**Opioids**

Most substance misuse in older people is due to prescription drugs, including medicinal opioid misuse. Pharmaceutical opioids are used for pain management, and also in the management of behavioural and psychosocial symptoms of dementia. Key issues related to (licit and illicit) opioids include their addictive nature, interactions with alcohol and other substances, and risks of serious harm, including death, with misuse. Recent evidence suggests there is a strong association between opioid analgesic use in the elderly and increased incidence of falls and injuries (Buckeridge et al, 2010).

Australian research has demonstrated that oxycodone prescriptions have increased, particularly among older Australians, although it is difficult to differentiate appropriate prescribing for an ageing population from non-medical use in that data set (Roxburgh et al, 2011). Non-medical use of prescription opioids may include harms such as overdose, injecting and diversion (Roxburgh et al, 2011). Older people misusing medication for pain management has contributed to an increase in death from heroin and other opioid drugs. In the US, the over 65 age group has the highest rate of deaths attributable to opioids prescribed for non-malignant pain (Holmwood, 2011), and oxycodone contributed to the largest number of all drug-related deaths in 1998-2005 (Roxburgh et al, 2011). In the Australian research the mean age was 43.6 years. In half the cases of oxycodone-related death, it had been prescribed to the decedent, and half had a history of chronic pain or a chronic medical condition. 27% were recorded as suicides (Roxburgh et al, 2011).

Consulted stakeholders identified a range of issues related to pharmaceuticals and older people. These included those related to pain and pain management, medication interactions with alcohol, and prevalence and management of multiple medications.

The issues stakeholders identified in relation to pain and pain management included: a general poor understanding of pain amongst clinicians; the over prescription of opioids; the reduced tolerance to pain among the opioid substitution therapy population; lack of understanding or use of allied health and non-pharmacological approaches; and poor access to multidisciplinary pain clinics.

Broader medication issues were also identified by stakeholders, including the over-prescription of benzodiazepines and psychotropics as well as opioids as above. Stakeholders reported the contraindications of alcohol with medications including blood thinners, central nervous system medications, anti-hypertensives, and sleep medications is another area of low understanding in the community, and that the prevalence of use of these medications increases from ages 50 and 60. The management of multiple medications in older people was another reported issue, with many older people being prescribed multiple medications without review or assessment of contraindication and risk.

**Tobacco**

**KEY MESSAGES: Tobacco**

In addition to the well published health risks for all smokers, there are specific risks pertaining to older people including smoking being a risk factor for cognitive decline and dementia, and having implications for medication metabolism.

The ill health effects of tobacco smoking are well established for all age groups. In addition to the well published health risks for all smokers, there are specific risks pertaining for older people with drug and alcohol issues including smoking being a risk factor for cognitive decline and dementia, and nicotine use having implications for medication metabolism.

Rates of current, past light and past heavy smoking in a study on general practice patients in Australian aged 60 years and over were 6, 16 and 21% respectively (Christensen et al, 2006). Smoking is the largest cause of premature death in the UK (Crome et al, 2009) and is a risk factor for cognitive decline, loss of grey matter and dementia (Almeida et al, 2011; Christensen et al, 2006). Tobacco smoking is a significant comorbidity risk for older people with substance use issues. Zimmerman, Lubman & Cox (2012) reviewed studies on rates of tobacco use in people with mental illness, and reported prevalence of smoking among this population group is high. Approximately 50% of people with psychiatric disorders are reported as smokers, with prevalence rates of 70 to 80% among people with schizophrenia and related psychoses, compared to prevalence rates of 21% for the general population (Zimmerman et al, 2012). Excess caffeine consumption is also worthwhile mentioning despite being out of scope for the project, as it often co-occurs with mental illness and high levels of smoking (Zimmerman et al, 2012). Excess caffeine intake can produce a variety of psychiatric symptoms including anxiety, depression, panic...
attacks, psychosis and delirium, and also can result in drug interactions with psychoactive medications and affect peripheral drug metabolism (Zimmerman et al, 2012).

Addressing smoking in mental health and drug and alcohol services and their target populations is a current NSW Health priority in the context of addressing smoking in NSW Health facilities and services, as well as within broader NSW population health and tobacco strategies. Counselling and medical advice are effective in aiding smoking cessation and nicotine replacement therapy (NRT) appears safe and effective in older people (Abdullan & Simon, 2006). Tait et al (2006) found older smokers can be engaged successfully in a brief intervention plus NRT as aids to cease smoking.

Specific groups and considerations

Specific populations

KEY MESSAGES: Specific Populations

There are a number of populations who experience particular vulnerabilities with regards to substance misuse and/or ageing. There is little literature available regarding the needs of these populations although it is likely that specific, coordinated service responses and key partnerships will be required.

Within the broader population of older people with substance use issues, there are specific groups of people with specific needs or vulnerabilities, such as: those who experience abuse; Aboriginal people; CALD communities; people living in rural and remote areas; people who are homeless or those who are vulnerable to becoming homeless; people with concurrent mental health problems; older prisoners; people living with HIV/AIDS; people who are lesbian, gay, bisexual, transgender or intersex individuals (LGBTI); and older adults with intellectual disabilities.

There is limited literature available around specific older populations or older populations with particular needs and substance misuse. There is a gap in the published literature where age, substance misuse and culture intersect. Issues such as the navigation of health service systems, language, life course, migration experience, diversity between and within cultural groups, experiences of ageing and poverty will all impact on access to and experience of health services for older people with substance use issues from CALD backgrounds and their families and carers.

The only literature identified as relevant for inclusion in this review related to older prisoners in the United States, and some prevalence information regarding older Aboriginal people and alcohol misuse, arising from the Koori Growing Older Well study (Radford et al, 2014).

In line with ageing of the population, international studies have found an increase in the proportion of older people in the prison population (Kakoullis, Mesurier, & Kingston, 2010). In various studies abroad, older inmates are less likely to have used illicit drugs before incarceration but are more likely to have misused alcohol (Kakoullis et al, 2010). A specific study in Iowa showed substance misuse problems in 71% of inmates over the age of 55 years, with alcohol being the primary substance used. However, these people were also significantly less likely to have received treatment for the substance abuse (Kakoullis et al, 2010). Whilst not age based, the 2009 NSW Inmate Health Survey demonstrated that much higher proportions of inmates were current smokers, drank at risky levels or at levels indicating dependence in the year before incarceration, and had ever used illicit substances, than the general population of NSW (Indig et al, 2010). The psychiatric health of inmates is also collected in the NSW Inmate Health Survey, and in NSW high rates of suicide attempts, self harm and depression are reported (Indig et al, 2010). Older people are relatively isolated in the prison environment and the environment is generally structured to a younger population. Older prisoners’ physical health is also worse than younger prisoners and older people in the community, and health issues may not be recognised or treated: in a British study 55% of inmates aged over 65 years had active symptoms of psychiatric disorder (Kakoullis et al, 2010), which is higher than other age groups. A third of those aged 65 years and over in a UK study were dependent on alcohol (Kakoullis et al, 2010), and 19.5% in a study in Sweden. Drug and alcohol abuse is a predictive factor for mental illness (Kakoullis et al, 2010). Access to appropriate services relies on the mental illness being detected and the literature highlights the potential roles of prison staff and OPMH psychiatry liaison services in recognising issues, assessment and service development.

Consultation with NSW Health Justice Health and Forensic Mental Health Network identified that there are many issues and opportunities related to older people in the justice system who have or have had substance misuse issues. These echo some of
the issues identified in the literature above such as levels of comorbidities, and also relate to supporting successful discharge and access to ongoing community supports.

Aboriginal health issues are particularly pertinent, with the *Koori Growing Old Well* study demonstrating 20% of Aboriginal people aged 60+ were current heavy drinkers – 29% men, 14% women (Radford et al, 2014) which highlights a significant gap in need and provision of services. Aboriginal people are considered ‘in scope’ from the age of 50 for this project, acknowledging the premature ageing and high levels of ageing-related comorbidity experienced by Aboriginal populations; noting that some drug and alcohol services consider Aboriginal people to be eligible for older peoples’ services from the age of 45 years.

Consultation with the AH&MRC of NSW highlighted specific cultural issues related to accessing mainstream services, and problems with recognition related to Aboriginal families often dealing with problems within the family unit. There are Aboriginal Drug and Alcohol Network (ADAN) services available in many parts of NSW, who were also involved in the project’s consultation, and identified that the separation of families to allow participation in residential rehabilitation is a particular issue for many older Aboriginal people with substance use issues. Family-centred care, and trauma-informed care were identified as needs for Aboriginal people in using drug and alcohol services; and aged care workers in Aboriginal Medical Services were identified as a potential access point in the system for older Aboriginal people, if these workers were engaged and provided with education and appropriate screening tools.

With regards to CALD communities in NSW, it is noted that CALD communities are diverse and varied. Of significance, however, is a common issue across many cultures where members of that community may be more inclined to be compliant with health professional recommendations, because culturally it would be seen as rude to speak up or disagree. This is especially true amongst older members of CALD communities where clients may accept a service plan without understanding its implications. The idea and concepts of substance dependency may not be well understood by many CALD communities, and traditional service responses are often Anglo-centric and may inadvertently exclude CALD communities through their service design or approach. Additionally, there are many different cultural concepts related to drug and alcohol use that may be unfamiliar to mainstream services such as ‘hosting’ where the safe service of alcohol is compromised because of the cultural need to be a good host. Furthermore, the use of homemade alcohol is not often expressed in terms of standard drinks and can be misleading. Often CALD communities are isolated, and not highlighted in service planning processes. Stakeholders identified in consultation processes that different cultures view their older populations differently, which impacts on care and support, life roles and role transitioning.

### Comorbidities

**KEY MESSAGES: Comorbidities**

Older people with drug and alcohol issues are likely to experience comorbidities including mental health and physical health issues. Ageing and the associated increased incidence of physical health issues may result in reduced mobility, increased and multiple morbidities, and may impact on detoxification.

Whilst aged health services and older people’s mental health services are familiar with comorbidities and physical health issues common in older people, these issues are less familiar to drug and alcohol services and will require workforce and service development responses.

Comorbidities are a significant issue for older people with drug and alcohol issues, highlighted both in the literature and throughout stakeholder consultations. For older people with substance use issues, mental health and physical health issues are common comorbidities, and these are important considerations. Recent NSW research on older people accessing drug and alcohol services found the participants reported a range of physical and mental health problems, and rated their physical health and overall quality of life worse than younger clients (Lintzeris et al, 2015).

Comorbid mental health and substance use disorders are relatively common, with one Australian study of a community managed mental health service reporting 27.7% of study participants met criteria for an alcohol use disorder, and 28% met criteria for a cannabis use disorder. 77% of study participants had a psychotic disorder (Zimmerman et al, 2012). Further Australian research found that older people accessing drug and alcohol services in South East Sydney scored significantly worse on depression scales compared
to a broader Sydney based sample (Lintzeris et al, 2015). The UK Royal College of Psychiatrists 2011 *Invisible Addicts* report indicates there are high levels of psychiatric comorbidities in older people, including intoxication and delirium, withdrawal syndromes, anxiety, depression, and cognitive changes/dementia (RCPych, 2011). As summarised above, rates of smoking are also significantly higher among people with mental illness (Zimmerman et al, 2012). Age-specific studies are limited. However, the following are examples of literature regarding substance and/or alcohol use comorbidly with other presentations in older people.

Alcohol disorders can occur more commonly with mental health disorders in older people (Christensen et al, 2006). In Finland, a population study showed that 0.1% of adults have comorbid alcohol disorder along with mood and/or anxiety disorders and a US study found that 38.1% of people aged 65 years and over with bipolar disorder had comorbid alcohol disorders (Christensen et al, 2006). Older people also frequently use alcohol and prescription medications (Christensen et al, 2006). A study of Finnish adults aged 75 years and above found that 86.9% used both alcohol and medicine on a regular basis, including those known to have an interaction with alcohol (Christensen et al, 2006; Aira et al, 2005).

Other studies of comorbidity in primary care found a 27% increase in comorbidity in those aged 75-84 years due to a dependence on illicit substances (such as benzodiazepines), and this was also associated with delirium (McKay, 2013). The UK Office for National Statistics *Study of Psychiatric Morbidity* (cited in McKay, 2013), also showed a decrease in lifetime and past use of any illicit drugs from aged 55 to 69 but an increase in people aged 70 to 74 years. One study found that the prevalence of substance use disorders in a specialist geriatric outpatient clinic was 20% (Woo & Chen, 2009).

Drug and alcohol use are also important contributing factors to be recognised in older people with other health issues such as delirium, falls, stroke or seizures (Holmwood, 2011).

NSW research found high levels of comorbidities amongst a group of older drug and alcohol service users, with over half reporting lifetime health conditions of liver disease, head injury and/or loss of consciousness. Further reported comorbidities included pain conditions, depression, sleep problems and lethargy. Affected systems and condition included circulation problems, respiratory problems, gastro-intestinal problems, hypertension, cardiac problems, seizures, cancer, diabetes and stroke (Lintzeris et al, 2015). An American study of older methadone patients found comorbid mental health disorder prevalence of 57.1%, and high comorbid physical health problems - with 57.7% reporting fair to poor physical health (Rosen, Smith, & Reynolds, 2008).

A key message from Draper et al (2015) is that when reviewing older people in hospital, comorbidity is the norm, and hence a comorbidity of alcohol misuse is not immediately apparent as compared to combinations of comorbidities seen in other geriatric patients. Whereas, within largely community-based drug and alcohol services, comorbidity amongst ‘older’ service users (who may be aged in their 50s) is a novel, significant and more challenging issue to be addressed.

Stakeholder consultations involved similar issues amongst older people with substance use issues, with physical health issues across a broad range of domains commonly identified. Ageing and associated increased incidence of physical health issues may result in reduced mobility; increased morbidities; the issue of multiple morbidities; and impact on detoxification. Chronic respiratory disease was further cited as a significant health issue for older people with drug and alcohol issues, likely related to elevated rates of smoking. Stakeholders also identified current rates of overdose are lower than historically recorded, which has resulted in substance abusing populations living to older ages and as such experiencing ageing-related issues for the first time.

### Cognition

**KEY MESSAGES: Cognition**

There are high risks for and rates of cognitive disorders in older people with substance use disorders, and increased risks for cognitive decline/impairment associated with alcohol use, benzodiazepine use, and tobacco smoking.

Cognitive impairment can impact on ability to access and maintain engagement with services, and has implications for the design of drug and alcohol services.

There are high risks for and rates of cognitive disorders in and amongst older people with substance use disorders, and increased risks for cognitive decline/impairment associated with alcohol use, benzodiazepine use, and tobacco smoking.
There is varying evidence about alcohol consumption available, with observational studies having demonstrated that older adults who drink moderately have better cognitive function than non-drinkers (Duru et al, 2010; Reid et al, 2002), whilst alcohol use at a disorder level, particularly at older ages, is associated with cognitive impairment and this may be irrespective of age of onset (Kist et al, 2014).

Survivors of substance misuse in later middle-ages, or chronic substance misusers, often have limited social function and high rates of cognitive impairment which can raise complex care issues, including medico-legal issues. How best to manage cognitively impaired patients or clients who are misusing alcohol has not been significantly explored. Cognitive impairment can affect people’s capacity to remember service appointments and to attend to activities of daily living (Lintzeris et al, 2015), and also ability to remember how many drinks have been consumed, for example. Cognitive impairment can also impact on capacity to consent to treatment and support, and there are significant social and legal implications of coercive treatment and/or accommodation placement when capacity is unknown.

Consulted stakeholders, particularly those in drug and alcohol services, identified cognitive impairment as a significant issue for older people with substance use issues. The issues identified were particularly around: accessing and maintaining engagement with services, for example behavioural issues related to frontal lobe damage, which can result in reduced access to services through exclusion or through missing appointments; difficulties related to accessing neuropsychology testing, and the lack of appropriate screens for older people with substance use issues.

A recent study in NSW found a high proportion of older clients of OST and alcohol services had severe cognitive impairment (Lintzeris et al, 2015). The authors highlight that with such high prevalence, the clinical implications for drug and alcohol services are that all service structures and clinical care need to accommodate the needs of people with cognitive impairment.

Case vignette 2: Cognitive impairment and medico-legal issues

Case vignette: ‘Mr C’

Mr C was a 79 year old male with a history of alcohol misuse and associated cognitive impairment, and was taken by his family to drug and alcohol services for further management and assistance in determining whether he fitted the criteria for a Guardianship application. Guardianship was contingent on a neuropsychological assessment following a period of abstinence. Mr C was reticent to engage with any health personnel who threatened his ability to drive.

There were many risk issues, including that when his licence was confiscated, Mr C continued to drive regardless, and also owned guns which were kept at home and gave rise to him being at risk of harming others in the community. Mr C was not able to maintain independence in his ADLs due to his cognitive status. The Aged Care Assessment Team (ACAT) assessed him but felt that he fell outside of their service scope with his ongoing alcohol consumption. For a time, Mr C effectively ‘fell through the gap’.

Mr C did eventually participate in detox, after extensive persuasion. A neuropsychological assessment was then able to be undertaken with a subsequent successful Guardianship application.
Pain

KEY MESSAGES: Pain

The prevalence of chronic pain increases with age in Australia, and is higher amongst older women, and older people of lower socioeconomic status and of poorer health. Pain can have a significant effect on functioning and quality of life, and is highly prevalent in older people, who often have multiple comorbidities and consequently take multiple medications.

Opioids can be an effective treatment for chronic pain, but their use is associated with a range of potential harms. One is the potential for misuse, in addition to physical health risks. There have been significant increases in oxycodone prescribing over the past decade, particularly for people aged 80 and over, and opioid prescription peaks in Australia for people aged 80+.

Stakeholders consulted for this project reported a lack of understanding or use of allied health and non-pharmacological approaches to managing pain, and poor access to multidisciplinary pain clinics, and this has implications for substance misuse in older people.

Pain has been mentioned in this report under the pharmaceutical misuse section. However, it is a complex area and warrants particular attention. The prevalence of chronic pain increases with age in Australia, and is higher amongst older women, and older people of lower socioeconomic status and of poorer health (Nicholas & Roche, 2014c). It has been estimated that between 42-85% of older people in various settings experience chronic, noncancerous pain, and that less than half are effectively treated (Kovach, 2013; Levi-Minzi et al, 2013). Pain can have a significant effect on functioning and quality of life, and is highly prevalent in older adults who often have multiple comorbidities and consequently take multiple medications (Gilson, Bryant & Judd, 2014).

Opioids can be an effective treatment for chronic pain, but it is recommended they are used only after other non-pharmacological and pharmacological approaches have not been successful, and their use is associated with a range of potential harms (Nicholas & Roche, 2014c). However, Roxburgh et al (2011) found significant increases in oxycodone prescribing over the past decade, particularly for people aged 80 and over. One study identified the regular doctor as the primary source of prescription opioids, and that under-treatment of pain can also be an important issue (Levi-Minzi et al, 2013). Over 40% of the sample in that study reported severe depression and 30% reported severe anxiety, which are conditions are often associated with chronic pain (Levi-Minzi et al, 2013). People with dementia receive less assessment and treatment for pain than older adults who are cognitively intact, and opiates may be highly effective as a treatment for discomfort. While pain is an obvious target for opioids, experience in palliative care settings suggests that there may be a broader role for the relief of more general distress (Fainsinger, 2000).

A Cochrane editorial group are currently further investigating the role of opioids for agitation in dementia, and note that to date, a small number of reports and at least one study have begun looking at a specific role for opioids for agitation in dementia. Others have incorporated opioids as part of a systematic approach to detecting and treating pain in this setting (Brown et al, 2012).

One of the potential harms associated with opioid use is the potential for misuse. Data from US national surveys indicates that prescription opioid misuse is increasing and therapeutic exposure to opioids can correspond to an increase in misuse (Levi-Minzi et al, 2013). The findings suggested that elderly patients may misuse their prescriptions for pain, and highlighted the need to educate those prescribing pain medications to older people, as well as identification of substance abuse (Levi-Minzi et al, 2013). People who are younger in age, have a history (current or past or family) of substance abuse or a comorbid psychiatric disorder are at higher risk for misuse (Levi-Minzi et al, 2013). Additionally, preliminary research conducted in Australia indicated there are older people who use alcohol to cope with the experience of pain. There are complex relationships between pain, drinking to self-medicate, poor mental and physical health, and risky drinking (Gilson, Bryant & Judd, 2014).

Stakeholders raised issues related to pain frequently in consultations. These issues are related to: a generally low understanding of pain amongst professionals; the over prescription of opioids; the reduced tolerance to pain among the OST population; lack of understanding or use of allied health and non-pharmacological approaches, and poor access to multidisciplinary pain clinics.
Needs of older people with substance use issues, and key issues arising from consultations

**KEY MESSAGES: Key Issues and Identified Needs**

Consulted stakeholders identified needs for an integrated or complex care approach, and appropriate accommodation options for older people with substance use issues. Decision making support and options for involuntary care were highlighted as needs for older people with significant cognitive impairment following a long history of substance abuse.

Key issues identified in consultations were numerous and varied, which may reflect the diversity present in people aged 50+ with substance use issues.

The most commonly identified issues related to cognitive impairment; recognition of substance use issues; ageism and therapeutic nihilism among the general community and health professionals; physical health issues; accommodation, finances and transport issues; the traditional approach of drug and alcohol services not aligning with the needs of older people; social isolation; lack of targeted health promotion activity; challenges in engaging carers; and the tension between voluntary and assertive treatment approaches and service structures.

Consulted stakeholders were invited to comment on the needs of older people in accessing and using services and treatment, and also the key issues for older people with drug and alcohol issues. Many of the responses echo the findings in the literature, and are summarised in the following sections.

**Needs of older people using services and treatment**

Stakeholders reported older people often have mobility and transport-related needs. Whether in a regional or metropolitan area, issues with mobility can affect older people’s ability to utilise public transport, and in regional and remote areas there is often inadequate public transport for people to access services regardless of mobility needs. Services and buildings are often not accessible for people with mobility issues, and there are related physical access needs.

It was identified that there is a need for appropriate supported accommodation for older people with substance use issues, particularly people in the ‘younger old’ cohort, who are not eligible or appropriate for aged care facilities. There is an identified need for support to be provided for older people with substance use issues to maintain their accommodation – when people are socially isolated with limited relationships and poor functioning this affects people’s ability to maintain accommodation. A separate issue that was raised related to people being able to maintain their accommodation whilst in residential rehabilitation – often a problem for residents of public housing.

Stakeholders identified that many older people with drug and alcohol issues have complex care needs and require a case management approach, with carer involvement and support where possible, and acknowledgement of the client’s own potential caring roles. Decision making support and involuntary treatment options were raised as needs for clients with a long history of substance abuse and/or cognitive impairment.

Family-centred care and trauma-informed care were identified as needs for Aboriginal people in using drug and alcohol services.

**Key issues identified by stakeholders**

Key issues identified by consulted stakeholders are numerous and disparate, reflecting the large age range in people aged 50+ and the different issues for the different cohorts. The more commonly identified key issues for older people with substance use issues are as follows:

- Stakeholders identified issues related to cognition. Cognitive impairment can create difficulties for people in accessing and maintaining engagement with services. For example, behavioural issues related to frontal lobe damage can result in reduced access to services through exclusion or through missing appointments. Stakeholders also reported difficulties related to accessing neuropsychology testing and the lack of appropriate screens for older people with substance use issues.
Themes related to ageism, recognition, therapeutic nihilism, and stigma were identified at each consultation workshop. These themes are supported by the literature, with American research identifying that adults aged 75 and over had lower predicted probabilities of alcohol-related conversations with their doctors, and additionally the conversations were not prompted by the presence of clinical factors that have greater risk with low or moderate drinking such as medications or comorbidities (Duru et al, 2010).

Within older populations there can be low recognition that there is a problem with level of use, or low health literacy and access to self-help resources. Additionally there are low rates of recognition among health staff due to older people presenting with a variety of conditions, and particularly in the context of indirect presentations such as falls or physical health issues secondary to substance misuse. Separate to low awareness, ageist beliefs may exist among staff and carers such as drinking being the “last pleasure left in life”, and these may combine with or support nihilistic attitudes. For example: “They’ve been using for 40 years; what difference will I make?” Stigma regarding substance abuse was reported amongst older people (with the phrase “I’m not a junkie” used to exemplify this), as well as within the general public and amongst health professionals. Whilst social isolation can be a key issue for older people, conversely stigma in regional communities can impact on access to services where a lack of anonymity exists.

As noted previously, physical health issues across a broad range of domains were also commonly identified as key issues. Ageing and associated increased incidence of physical health issues may result in reduced mobility, increased morbidities and multiple morbidities, and impact on detoxification. Chronic respiratory disease was further cited as a significant health issue for older people with drug and alcohol issues, likely related to elevated rates of smoking. Stakeholders identified current rates of overdose are lower than historically, which has resulted in substance abusing populations living to older ages and as such experiencing ageing-related issues for the first time. Medication issues were identified, as detailed above, including those related to pain and pain management, medication interactions with alcohol, and prevalence and management of multiple medications.

Issues related to accommodation, finances and transport also featured commonly in stakeholder responses. Public transport is often difficult to access for people with ageing-related health issues, even when it is locally available, leading to transport being identified as an issue across the geographical areas consulted. Financial difficulties related to being reliant on a pension and/or using substances impact negatively on people’s ability to participate in the community, and may perpetuate social isolation. Finances can also impact on access to residential rehabilitation services, and on the ability to purchase private support services to maintain independent living in the community. There is a lack of appropriate accommodation options across the spectrum of needs, and people can find their accommodation at risk if entering a period of residential rehabilitation. It was noted that Guardianship Orders are often useful in supporting a person’s decision making, but can only be effective when there are appropriate service options to access. Within residential aged care facilities, skills and confidence of staff in dealing with substance using clients varies, as does prescription medication management. People are generally not able to continue maintenance therapy in residential care, which is a key issue in accommodation and service planning for maintenance therapy clients.

Stakeholders raised issues relating to the structure and ideology of drug and alcohol services. There was significant diversity across areas, with some stakeholders commenting that they are not well set up for outreach or assertive models, whereas others noted they were in fact able to provide appropriate services for older people such as home visits, but had not been aware that this was a need. The traditional service delivery model in drug and alcohol services involves consumers approaching the service to initiate treatment, and participants noted this can be incompatible with the needs of older people. In addition, the differences between drug and alcohol services and mental health services in terms of recovery focus were highlighted by one peak body – mental health has a relatively well established definition of recovery and recovery-focused services, which clearly states that recovery is not synonymous with being symptom free, whereas in drug and alcohol services the term “recovery” can be used when people mean “drug-free” (Helfgott & Wilkinson, 2012) which is at odds with a harm minimisation approach.

Social isolation can be a significant issue for older people. It may be related to major life changes, reduced mobility in the older old cohort, or unemployment or relationship and social breakdown in the younger old cohort, financial
difficulties, and/or homelessness. Alcohol may indeed play a positive part in social engagement and socialisation, as with younger age groups (Wilkinson & Dare, 2014), adding to the conflicting messages and attitudes present in this area. Australian research identified moderate alcohol use may be positively linked to social engagement, particularly in certain residential settings (Dare et al, 2014). Stakeholders noted socially isolated people in the ‘older old’ cohort may tend to use alcohol at home, without causing a disturbance to others and therefore are not identified as having issues as readily. Issues related to life stage transition and major life changes experienced by older people such as retirement, grief and loss, and divorce, can all impact on substance use and access to services. Going forward, the increase in divorce rates is likely to also impact on managing life stage transitions, socialising and using alcohol at older ages. Stakeholders noted some older people function well whilst working and using drugs or alcohol, and then decline rapidly on retirement, whilst others gradually increase alcohol use post-retirement to risky levels. Furthermore, survivors of chronic substance abuse were reported to often have limited family and social networks remaining. This is supported by a NSW study of older drug and alcohol service users, which found the majority of participants lived alone, were not in the workforce, did not receive assistance from carers despite difficulty in completing activities of daily living, and had a score on the Lubben Social Network Scale which indicated high levels of social isolation (Lintzeris et al, 2015).

Consultation participants highlighted that there is a lack of health promotion activity or resources targeted towards older people in relation to drugs and alcohol. Additionally, the messages to older people around safe use of alcohol are not clear or agreed, and whilst the National Health and Medical Research Council Australian Guidelines to Reduce Health Risks from Drinking Alcohol do cover issues specific to age groups, there are no specific guidelines on safe/harmful drinking levels in Australia. It was also noted that people may have been having their substance use issues managed by their GP, possibly due to stigma associated with using traditional drug and alcohol services, or because their substance use was in the ‘risky’ level rather than disorder category, but as they emerge from middle age and previous generally good health into older ages, comorbidities arise and the burden of care and complexity increases on primary care.

Stakeholders reported a range of issues related to the engagement of carers in drug and alcohol services. Engagement of carers was not traditionally part of standard practice in drug and alcohol assessment and therapies. Many services now embed carer engagement in their processes, and carer engagement in referral processes was reported to improve service access. However, there can often be issues with social isolation and lack of carers or supports – both for members of the ‘younger old’ cohort who may have been in treatment for many years, and members of the ‘older old’ cohort. Further carer-related issues were highlighted in that for some members of the ‘older old’ cohort, or people being identified as having a problem with alcohol or substances for the first time, carer presence can create issues with disclosure and stigma, and negatively impact on recognition issues. Conversely, stakeholders identified the need to explore caring roles holistically, as members of the same household can experience similar lifestyle and/or substance use issues. When discussing in-home services, which some stakeholders identified as being a positive option for older people, it was noted these services can create extra carer burden and can also raise safety issues.

Stakeholders expressed a range of views regarding involuntary and voluntary treatment. Whilst the Involuntary Drug & Alcohol Treatment (IDAT) model was seen as successful and appropriate for some older people by some stakeholders, the lack of community-based involuntary treatment to follow up with post-discharge from IDAT or residential rehabilitation was seen as an issue. Other stakeholders felt a voluntary model was generally most acceptable, with changes including ‘warm referrals’ and more assertive outreach elements incorporated into normal practice.

Gambling has been raised as an emerging and important issue for older people, which can be associated with drug and alcohol issues for older people. Addressing gambling is out of scope of this project but would benefit from exploration in future work.

Substance misuse can be associated with family and domestic violence, and this is not only an issue for younger people. Services need to be aware of the increased risk with older people as with younger people.

The issue of elder abuse was raised by stakeholders. Older people with substance misuse issues have vulnerabilities in forms of abuse toward and from other people, including family and community members. There can be particular vulnerabilities for specific populations.
There is limited research on treatment for older people with substance abuse, and many of the studies completed to date are limited by small sample sizes. What research there is tends to be from the US and revolves largely around alcohol. However, the overall finding of the studies undertaken is that treatment for older people can be effective (Crome et al 2009; Keurbis & Sacco 2013), in that older patients respond to treatment at least as well as younger patients in terms of compliance and outcomes (McGrath, Crome, & Crome, 2005; EMCDDA, 2008), and in some cases have better outcomes (Keurbis & Sacco, 2013; RCPsych, 2011).

Very few adults with an alcohol problem receive formal help (Spencer, 2001). In the US, adults aged 50-59 years were more likely than those aged 60 and over to use substance abuse treatment. Alcohol and other drugs should be assessed and appropriately managed when patients present with related problems. Special care is needed in the management of alcohol withdrawal in older people to manage the associated risks (Holmwood, 2011).

A clearer distinction may be required between different types of substance use, as disorders among prescription drug users and illicit drug users may have different behavioural and clinical manifestations (Gossop & Moos, 2008). A study looking at how individual patient characteristics predict substance abuse treatment initiation among older veterans found that patients who initiated treatment following evaluation had more years of education, better cognitive status, and more symptoms of substance abuse and depression, compared with patients who did not initiate treatment. In logistic regression analysis, Cut-Down, Annoyed, Guilty, Eye-opener (CAGE) and Mini Mental State Exam (MMSE) scores independently predicted treatment initiation (Satre et al, 2004).

Service Mapping

Drug and alcohol services

The NSW Ministry of Health uses historical and survey data to plan drug and alcohol services. Several years ago NSW Health led a national project (2010-2013) which developed a population based planning model to estimate the need and demand for drug and alcohol health services across Australia.

While currently few drug and alcohol services in NSW cater specifically for the needs of older people, funding is allocated to Local Health Districts (LHD) to provide non age-specific treatment services, which can be accessed by older people. Services provided by frontline drug and alcohol workers include:

- Early and brief intervention
- Pharmacotherapy services
- Detoxification and withdrawal management services
- Rehabilitation and counselling services
- Case management and assertive outreach for drug and alcohol users seeking assistance
- Addiction medicine services
- Health promotion and community engagement, and
- Consultation liaison services.

In addition to those direct services provided by LHDs, the NSW Government provides funding for non-government organisations and other agencies to also provide:

- Residential rehabilitation services
- Education and prevention services
- Advice and information
- Mass media and campaigns, and
- Encouraging pharmacists and GPs to engage with the pharmacotherapy program.

Further details of these drug and alcohol services are included at Appendix B: Service Mapping.
Older people's mental health services

The key components of Specialised Mental Health Services for Older People (SMHSOP) are community teams, acute and non-acute inpatient services, and community residential care service models delivered in partnership with residential aged care providers in some areas.

- Community teams have three major functions: specialist mental health assessment and treatment, care planning and case management for older people with severe and/or complex mental health problems. These are available in each LHD.
- Acute SMHSOP inpatient services provide specialist psychiatric care for people who present with acute, severe symptoms of mental illness. Acute SMHSOP inpatient units may be discrete facilities or sub-units within acute mental health facilities or acute hospitals. They are located in a number of LHDs around NSW.
- Non-acute/sub-acute SMHSOP inpatient services have a primary focus on interventions to reduce functional impairments that limit the independence of the person and promote recovery. They provide specialist clinical assessment, treatment and rehabilitation where patients are not able to be managed in the community, with an expectation that consumers will improve sufficiently for discharge to a mainstream service or community setting with additional support from SMHSOP and other services. These units are located in a number of LHDs in NSW.
- Community residential care service models delivered in partnership with residential aged care providers are available in some areas. These models provide long term care for people with severe and persistent psychiatric symptoms associated with dementia and or mental illness through partnerships between SMHSOP, aged care services/Aged Care Assessment Teams (ACATs) and the residential aged care sector. This includes the Mental Health Aged Care Partnership Initiative (MHACPI) model, delivered in two sites in NSW.

The target population is generally people aged 65 years and over with a diagnosable mental health disorder or problem. However, SMHSOP also provide assessment and care for some ‘younger’ old people with complex comorbidity issues including mental illness, dementia, acquired cognitive impairment and/or substance use issues who have age-related problems causing significant functional disability. The NSW Service Plan for SMHSOP 2005-2015 notes that SMHSOP will not generally provide services for older people with a primary diagnosis of drug and alcohol disorder, but will exercise appropriate flexibility in providing assessment for older people with complex or unclear aetiology. A flexible approach is one of the core principles of care. The service utilisation data in the following section indicates SMHSOP has indeed been providing services for people with a primary or secondary diagnosis of drug and alcohol disorder, and that the number of clients with a drug and alcohol diagnosis are growing.

Access and referral arrangements are generally via the Mental Health Line (1800 011 511) or directly to the local mental health or SMHSOP service.

A more detailed summary table of the SMHSOP service elements is included at Appendix B: Service Mapping.

Adult mental health services

The key components of adult mental health services are a combination of ambulatory services delivered usually by multidisciplinary community teams; acute, subacute and non-acute inpatient services; and community based services that aim to support quality of life, psychosocial functioning, integrated accommodation and living needs, and carers.

- Adult ambulatory mental health services encompass three key service elements, which may be delivered by separate teams or staff. These are acute assessment and treatment services; continuing care services, and community treatment services. While all LHDs have ambulatory teams, the range of services provided by teams varies and LHDs should be contacted if more detail is sought on the availability of a particular type of ambulatory service.
- There are a range of further services delivered by NGOs complementing clinical mental health services, including the Housing and Accommodation Support Initiative (HASI), and a range of Mental Health Support and Rehabilitation Services such as supported accommodation; psychosocial rehabilitation day programs; mutual support and self-help, and the Family and Carer Mental Health Program. LHDs should be contacted if more detail is sought on the availability of a NGO service in the region.
- Adult inpatient services encompass emergency care including Psychiatric Emergency Care Centre (PECC); adult acute inpatient services; adult sub-acute inpatient services, and secure non-acute extended care inpatient services. Acute inpatient units are found in all LHDs, whilst PECCs are generally only available in larger metropolitan and a few larger regional hospitals and subacute and non-acute varies.
The target group are adults 18-64 years, with serious mental illness or severe disorders with significant levels of disturbance or impairment. The target group may have complex needs, such as comorbidity, and includes those whose problems have not responded to primary care interventions, and people at risk to themselves or others. Access and referral arrangements are often initially through GPs, family members or friends, or directly by the local mental health service, or via the State Mental Health Telephone Access Line (1800 011 511).

A more detailed summary table of adult mental health service elements is included at Appendix B: Service Mapping.

**Service Utilisation Data and Analysis**

**Introduction and data rules**

An extensive set of data has been provided by the NSW Ministry of Health mental health information unit (InforMH) to assist in highlighting rates and patterns of access to existing NSW Health drug and alcohol and mental health services by older people with drug and alcohol issues, over the past ten years. Some broad patterns and also items of particular interest are highlighted in the following section. The section is broken down into drug and alcohol service data, ambulatory mental health service data, inpatient mental health service data, and also hospital admissions data. The mental health sections contain data for both adult and older people’s services, presented separately or combined as appropriate. It is important to note that all data relates to either a principal or a secondary drug and alcohol diagnosis, not only to a principal diagnosis.

This state level data is presented in the following section with an analysis of implications for services and project recommendations. LHD level data has been provided and will be made available separately to this report to support future LHD responses to project recommendations.

Diagnostic code groupings and data rules are included at Appendix F: Data Definitions. Please note drug and alcohol service data relates to episodes of care only, whilst mental health service data relates to either individual clients or episodes of care/contacts as indicated. It is important to note that this data pertains specifically to the services noted above. There are limitations to the available data, such as different recording systems between sectors, and changes in recording over the collection period as noted in Appendix F: Data Definitions. Moreover, it cannot be extrapolated from the available data what proportion of the recorded opioid use is attributable to use of illicit opioids such as heroin, pharmacotherapy such as methadone, or misuse of pharmaceuticals such as oxycodone. As oxycodone is a key and growing drug of concern for older people, it is something to bear in mind when considering the opioid data that follows.

Furthermore, the NSW OTP is delivered across a variety of settings, the majority being community pharmacies with some in hospital and LHD based services (AIHW, 2014c). Dosing is not recorded as a contact in the following data. An episode of care related to opioids as the drug of concern may be for people on the OTP, or it may be related to other opioid users. Also, it will only be related to other services provided, not OTP dosing. Where the ‘main service provided’ is ‘maintenance pharmacotherapy’, this will either be case management or prescribing for the OTP clients being seen in LHD based public services. Broader OTP data is looked at in more detail in the National Opioid Pharmacotherapy Statistics Annual Data (NOPSAD) report (AIHW, 2014c) and some key points are included in this report (see ‘Ageing treatment populations’, from page 23).

In addition to this service utilisation data, feedback in consultation processes highlighted a perception amongst relevant services that service users are ageing. Key perceived trends included increasing numbers of older people in drug and alcohol counselling services and in residential rehabilitation services; the ageing of treatment populations, particularly opioid substitution therapy (OST); increasing incidence of alcohol-related issues seen by aged health and orthopaedic services/staff; increasing OTC codeine use by older people; and increased prescription of antidepressants in older people post life events (with low access to/uptake of counselling and non-pharmacological approaches to grief and loss management).

Other service utilisation issues reported included that aged health/geriatric medical services often only see the older people with substance use issues once at a very complex stage, and that hospital DACL staff tend to see older people with substance use issues more commonly than other points of contact in the service mix.
Some stakeholders highlighted relevant data regarding their own services, including:

■ One-third of a particular residential rehabilitation service’s clients at Central Coast are now classified as ‘older’, which is a significant change from previous decades.

■ A residential rehabilitation service attending the Westmead consultation reported 15% of its clients are older people, predominantly from the ‘younger old’ cohort. This figure would be 20% if incorporating Aboriginal consumer statistics, with ‘older’ clients defined as 45 years and over.

■ Mid North Coast drug and alcohol services reported that 26.4% of their registrations over the preceding year were consumers over 50 years old, and 10% over 60 years.

It is worthwhile noting that whilst the above higher rates were reported in some services, other consultation participants indicated that they did not see older people in any great numbers in their services. Additionally, the NGO minimum data set did not show a significant increase in age of service users over the period 2010-2013. These reports may be related to issues with identification and recognition, and indicate a likely high level of variance across services and geographical locations. LHD level data is able to be provided to LHDs to assist in local planning, in support of project recommendations.

Some examples of utilisation of specific services by older people are included in Section 2: Drug & Alcohol Issues in Older People of this report. These include the ageing of the injecting drug population, as demonstrated by the data provided by the Sydney MSIC (from page 24), and the ageing of the OTP population demonstrated in the NOPSAD report and highlighted from page 23. Furthermore, MERIT (Magistrates Early Referral into Treatment) data from the past decade has been analysed and demonstrated that whilst numbers of people aged 50 and over in this program are low, they are also increasing.

Drug and alcohol consultation/liaison example

DACL service utilisation data is not centrally available at this time. However, in accordance with the consultation feedback indicating the importance of this service for older people, Sydney LHD provided a snapshot of their DACL service utilisation. The following figure (6) depicts the proportion of DACL service users by age ranges, aggregated over a three year period. Figure 6 demonstrates that 36% of the local DACL service utilisation was by clients aged 50 and over. In the same time period, the corresponding percentage of service utilisation of statewide LHD drug and alcohol services by people aged 50 and over was less than half this proportion, at 16.3% (see Figure 7). This supports advice from consulted stakeholders that DACL services can have an important role in identifying older people with substance use issues, and supports project recommendations to explore and maximise the potential of DACL roles as a referral point in the service mix.

Figure 6: Sydney LHD DACL service utilisation by age group, average over 2011, 2012 and 2013
Drug and alcohol services

KEY MESSAGES: Drug and alcohol service utilisation data

In the last ten years there has been a steady increase in drug and alcohol service utilisation for the 50-64 year age group, with a moderate increase in closed treatment episodes for those aged 65+ years.

Alcohol is the ‘principal drug of concern’ for the large majority of closed treatment episodes, with opioids the next largest group - although in much smaller numbers. Opioid use has steadily increased over the period, with cannabinoids and other hallucinogens also increasing.

The main services provided for those aged 50+ utilising drug and alcohol services across the ten year period are ‘counselling’, ‘support and case management only’ and ‘inpatient consultation’, followed by ‘outpatient consultation’ and ‘assessment only’

The most common service delivery setting for those aged over 65 is a residential/inpatient setting. Non-residential/outpatient/community settings are the most common service delivery setting for those aged under 50 years of age. For those aged 50-64, there is almost an even mix of both these settings.

The numbers of older people with substance use issues seen in LHD drug and alcohol services

Figure 7 demonstrates that there has been a steady increase in drug and alcohol service utilisation for the 50-64 year age group, with a moderate increase in closed treatment episodes for those aged 65+ years.

Figure 8 demonstrates a steady increase in drug and alcohol service utilisation for all age groups 50+ over the ten year period July 2004 – June 2014, with the most dramatic increases in the 50-54, 55-59 age cohorts and slightly less so for the 60-64 age group. As a proportion of all those receiving care in drug and alcohol services, the broader target group of people aged 50+ represent a growing cohort of service users, with the number of service users under 50 decreasing. This is because there has been a substantial increase in the group aged 50-64 over the last 10 years, especially in 50-54 year olds (Figure 8). This pattern is also seen in mental health inpatient units (Figures 28 and 29). This is being largely driven by increases in treatment for opioids, cannabinoids and cocaine (Figures 9-11) and probably the ageing of the population generally. The data does not tell us whether changes are being driven by population increase in the baby boomer generation, or whether there is a cohort effect of different patterns of substance use, although the latter is implied and supported by the literature. It is still unclear whether the trends in the 50-64 year old cohort over the past decade will persist into the 65+ year old cohort, but this is likely to be the case.

Figure 7: Episodes of care by year, by age cohorts across the ten year period July 2004 – June 2014
What are the principal drugs of concern for older people seen in LHD drug and alcohol services?

Figure 9 shows alcohol is the ‘principal drug of concern’ for the large majority of closed treatment episodes for those aged 50+ utilising LHD drug and alcohol services, with opioids the next largest group – although in much smaller numbers by comparison. The graph also shows a steady increase in alcohol and opioid use over the period.

**Figure 9:** ‘Principal drug of concern’ for drug and alcohol services closed treatment episodes for clients aged 50+ by year
When the data is analysed further by age cohorts, the drugs of concern are substantially different in the 50-64 age group compared with the 65+ age group. For the 65+ age group there is currently virtually no use of cannabinoids, cocaine and opioids. This is likely to change as the 50-64 year age group further ages. It is not clear from the data whether some of this population group ‘transition’ to age-specific services from the age of 65.

Figure 10 shows that when compared to other ‘principal drugs of concern’ (excluding alcohol in this instance for clarity – See Figure 9 for total proportions) for closed treatment episodes for those aged 50+, opioid use has steadily increased over the period, with cannabinoids and other hallucinogens also increasing. The majority of other substances, including sedatives and hypnotics and other stimulants have remained steady over the period.

Figure 11 demonstrates alcohol as the most prevalent ‘principal drug of concern’ in the period July 2013 – June 2014 for those aged 50+. Opioids, followed by cannabinoids are the next highest in prevalence, although occurring in much lower numbers.
Figure 12 demonstrates that besides alcohol, opioids are the most frequently reported ‘principal drug of concern’ (48%) for LHD drug and alcohol service treatment episodes for the data period Jul 2013 – Jun 2014. Cannabinoids are the next most frequently used, at 17%, with other hallucinogens and ‘other’ following - with 10% prevalence rate for each.

**The main service types provided to the older people in LHD drug and alcohol services**

Figure 13 demonstrates that the main services provided for those aged 50+ utilising drug and alcohol services across the ten year period are ‘support and case management only’, ‘counselling’ and ‘inpatient consultation’, followed by ‘inpatient/residential withdrawal management’, ‘outpatient consultation’ and ‘assessment only’.

**Figure 12:** ‘Principal drug of concern’ (less alcohol) for all closed treatment episodes in LHD drug and alcohol services for 50+ age group during the data period Jul 2013 – Jun 2014

- Opioid: 48%
- Sedatives and Hypnotics: 7%
- Other Hallucinogens: 10%
- Nicotine: 7%
- Cocaine: 1%
- Cannabinoids: 17%
- Other Stimulants inc. Caffeine: 0%
- Other: 10%

**Figure 13:** ‘Main service type’ provided for people aged 50+ across the ten year period to June 2014

- Support and Case Management Only: 26%
- Counselling: 20%
- Inpatient/Residential Withdrawal Management: 12%
- Outpatient Consultation (excluding withdrawal management): 19%
- Maintenance Pharmacotherapy: 3%
- Information and Education Only: 1%
- Day Program Rehab Activities: 1%
- Residential Rehab Activities: 2%
- Outpatient Withdrawal Management: 3%
- Inpatient Consultation: 9%
- Other: 1%
Figure 14 demonstrates that counselling was the most common ‘main service type’ provided for all age cohorts 50+ over the ten year period, with ‘assessment only’ and ‘support and case management’ also provided to a significant number of service users. ‘Support and case management’ and ‘counselling’ are the most common main service type provided for the 50-64 cohort with ‘inpatient consultation’, ‘support and case management’ and ‘counselling’ the most common service type for those aged 65+ years.

The types of service delivery settings utilised by drug and alcohol clients in LHD drug and alcohol services

Figure 15 demonstrates that while non-residential/outpatient/community settings are the most common service delivery setting for those aged under 50 years of age utilising drug and alcohol services, the most common setting for those aged over 65 is a residential/inpatient setting. For those aged 50-64, the setting is almost an even mix of both these settings. Relatively little service delivery occurs in the five other settings recorded – home, outreach, correctional, therapeutic and ‘other’ – with little variation in the proportion of these other services between age cohorts in client numbers across this range.

Figure 14: ‘Main service type’ provided by LHD drug and alcohol services by age group for the ten year period to 2014

Figure 15: Drug and alcohol ‘service delivery setting’ by age cohort across the ten year period to June 20
Mental health services

KEY MESSAGES: Mental health service utilisation data

People aged 50+ with a drug and alcohol diagnosis represent small but growing numbers in ambulatory mental health services.

Alcohol and then opioids are the main drugs of concern for adult and SMHSOP ambulatory service users aged 50+ with a drug and alcohol diagnosis. Opioid users in ambulatory adult mental health services are the group with the highest number of average contacts per year.

Higher numbers of the target population are seen in adult units than in older people’s units.

The broad trends in mental health inpatient units are that: alcohol misuse is clearly the most commonly identified substance use issue; opioids and cannabinoids are seen relatively frequently in the ‘younger old’ cohort; and all substance use declines with age among service users aged 50+, but sedatives/hypnotics decline the least with age.

Ambulatory mental health services

The numbers of older people with drug and alcohol diagnoses seen in combined adult and older people’s ambulatory mental health services

Figure 16 demonstrates that overall, people aged 50+ with a drug and alcohol diagnosis represent small but growing numbers in ambulatory mental health services. The proportion of total mental health service consumers is small, with an average of 5% over 10 years.

**Figure 16**: Combined adult and SMHSOP ambulatory services unique clients with a drug and alcohol diagnosis, by year, as a proportion of total unique clients over ten year period
Figure 17 demonstrates that there has been a sixfold increase in drug and alcohol-related contacts within ambulatory mental health services over the last decade.

Additionally, data relating to contacts for a drug and alcohol diagnosis each year was extracted, and Figure 18 depicts the average number of drug and alcohol contacts per unique individual with a drug and alcohol diagnosis with at least one contact in the 12 month period. This data suggests that there is a higher level of complexity with the ‘younger old’ cohort, requiring increased contacts.

**Figure 17:** Combined number of contacts with a recorded drug and alcohol diagnosis aged 50-64 and 65+, seen in both ambulatory adult and SMHSOP teams, by year, over ten year period

**Figure 18:** Average number of contacts for people 50-64 and 65+ by year, over ten year period
Are there generational changes to be observed over the previous 10 years?

The following two figures (19 and 20) present numbers of unique clients with a drug and alcohol diagnosis seen each year in ambulatory mental health services, by age ranges.

The adult ambulatory services show a clear trend of increasing numbers of clients with drug and alcohol diagnoses in the younger age groups, supporting the notion of generational changes. Whilst the numbers in SMHSOP community teams are low and more variable, they are also trending up. For SMHSOP ambulatory services, the highest numbers of clients with a drug and alcohol diagnosis are in the 65-69 age range (which is the younger end of SMHSOP’s main target population) with steady increases in the 70-74 year old age group and also in the younger old group of 50-54.

**Figure 19:** Numbers of unique clients each year with adult ambulatory mental health teams with a drug and alcohol diagnosis, for each 5 year age group, over ten year period

**Figure 20:** Numbers of unique clients each year with ambulatory SMHSOP teams with a drug and alcohol diagnosis, for each 5 year age group, by year, over ten year period
Drugs of concern: What substances are the key drugs of concern for older people with drug and alcohol diagnoses seen in ambulatory mental health services?

The following two pie graphs (Figures 21 and 22) depict the proportion of all substance groups for people seen in ambulatory mental health services with a drug and alcohol diagnosis, in the 2013-14 reporting year.

In the following figures, the 0% tobacco is almost certainly due to recording practices rather than prevalence, as there are widely understood elevated rates of tobacco smoking among mental health consumers. These figures demonstrate that similarly to drug and alcohol services, alcohol and then opioids are the main drugs of concern for adult and SMHSOP ambulatory service users aged 50+ with a drug and alcohol diagnosis.

**Figure 21:** People aged 50+ with a drug and alcohol diagnosis seen in ambulatory adult services, by substance type, 2013-14

![Pie chart for adult services](image1)

**Figure 22:** People aged 50+ with a drug and alcohol diagnosis seen in ambulatory SMHSOP services, by substance type, 2013-14

![Pie chart for SMHSOP services](image2)
Although not shown in a figure here, when the data is broken down further into age ranges and substance types it can be seen that the key substance diagnoses are alcohol and opioids for SMHSOP ambulatory service users both in the 50-64 and 65+ cohorts. Opioids users are seen relatively more commonly in adult ambulatory mental health services. Of all alcohol users in contact with mental health ambulatory services (adult and SMHSOP) in 2013/14, 33% were 50+, and of all opioid users in contact with mental health ambulatory services (adult and SMHSOP) in 2013/14, 11% were 50+.

What are the patterns of contacts per unique individual?

It is interesting to note that some service user groups have a higher average number of contacts per year for each unique person. Opioid users in ambulatory adult mental health services are the group with the highest number of average contacts per year (noting as per page 39, that this is not related to OTP dosing, and may be attributable to a range of forms of opioid use). Figure 23 below depicts the average contacts per individual client in both SMHSOP and adult ambulatory mental health services for opioid and alcohol users.

Inpatient mental health services

The numbers of older people with a drug and alcohol diagnosis seen in adult and older people’s inpatient mental health services

Figure 24 shows increasing numbers of people over 50 with drug and alcohol diagnoses seen in adult mental health inpatient units over the past 10 years. The total number of patients in these units has increased, so the proportions have not changed dramatically. However, the increasing numbers support the need for increased staff awareness and training regarding issues related to older people with substance use issues.

Further to the below graph, when numbers are averaged over the past 10 years, it is demonstrated that the average proportion of people with a drug and alcohol diagnosis who are aged 50+ in adult inpatient units is 24%. When averages are taken the for the past 5 years this increases to 27%, and over the past 3 years the average increases further to 34%.

Figure 25 demonstrates that a smaller number of people over 50 with a drug and alcohol diagnosis are seen in SMHSOP inpatient units than in adult inpatient units across NSW, and the proportion is also smaller. There has been a slight upward trend for the last three years.

Figure 23: Average number of ambulatory contacts per alcohol and opioid user aged 50 + in SMHSOP and adult ambulatory mental health services, 2013-14
Figure 24: Number of people with drug and alcohol diagnoses aged 50+ seen in inpatient adult mental health services, by year, over ten year period

![Graph showing number of people with and without drug and alcohol diagnoses seen in inpatient adult mental health services over a ten year period.]

Figure 25: Number of people seen in inpatient SMHSOP units each year aged 50+ with a drug and alcohol diagnosis, by year, as a proportion of total people seen, over ten year period

![Graph showing number of people with and without drug and alcohol diagnoses seen in inpatient SMHSOP units over a ten year period.]

Figure 26 portrays the trends as per above figures, but for combined adult and older people’s mental health inpatient units. People admitted with a drug and alcohol diagnosis aged 50+ have increased significantly over the ten year period.

Figure 27 shows that when the broad project target population of people aged 50+ is broken down into the two key age cohorts, the theme of generational changes in substance misuse is reinforced, with the data indicating that more of the ‘younger old’ cohort are seen in mental health inpatient units than the ‘older old’.

**Figure 26:** Combined number of people with drug and alcohol diagnoses aged 50+ admitted to adult and older people’s mental health inpatient units, by year, as a proportion of total people admitted

**Figure 27:** People with a recorded drug and alcohol diagnosis aged 50-64 and 65+, seen in combined adult and older people’s mental health inpatient services, by year, over ten year period
Figure 28 below depicts the same information, but with inpatient unit separations as opposed to unique people per year, and separating the cohorts to again demonstrate the generational changes.

The generational changes can be seen even more clearly when presenting the data by 5 year age range, as per Figure 29.

If the data from adult and older people’s mental health inpatient units is considered separately, it is evident that higher numbers of the target population are seen in adult units than in older people’s units.

**Figure 28:** Separations with a recorded drug and alcohol diagnosis aged 50-64 and 65+, seen in combined adult and older people’s mental health inpatient services, by year, over ten year period

**Figure 29:** Combined numbers of people with a drug and alcohol diagnosis admitted each year to combined older people’s and adult inpatient units, for each 5 year age stratification, by ten year period
What substances are the drugs of concern for older people with drug and alcohol diagnoses admitted to inpatient mental health services?

Figure 30 demonstrates that the majority of separations for people aged 50+ with a drug and alcohol diagnosis in adult mental health units were related to alcohol use, with some related to cannabinoids and opioids. All substance use declined with increasing age.

The main substance seen in SMHSOP inpatient units was alcohol, with a clear peak in the 70-74 year age group, with sedatives/hypnotics and tobacco also present (despite low numbers).

The broad trends in mental health inpatient units are that:

1. alcohol misuse is clearly the most commonly identified substance use issue,
2. opioids and cannabinoids are seen relatively frequently in the ‘younger old’ cohort, and
3. all substance use declines with age among service users aged 50+, but sedatives/hypnotics decline the least with age.

Figure 30: Number of separations with drug and alcohol diagnosis in adult inpatient units in the reporting year 2013-14, by substance type and age ranges
Hospital services

KEY MESSAGES: Hospital Data

Whilst the numbers of older people being admitted to drug and alcohol beds are relatively small, they are increasing.

People aged 50+ with a drug and alcohol diagnosis are most likely to be seen in multiple bed types prior to a hospital discharge.

Alcohol is the predominant drug of concern for people aged 50+ with a drug and alcohol diagnosis admitted to hospital. Tobacco represents a higher proportion of hospital separations than for mental health service utilisation, which is in line with its well-known causes of ill health and morbidities. Opioids represent a greater proportion of hospital separations for the ‘younger old’ than the ‘older old’ cohort, which is echoed in mental health service utilisation.

What are the generational changes and patterns of hospital use by the target group?

Figure 31 shows that drug and alcohol-related separations have increased markedly for people over 50 in the last 3 years, whilst drug and alcohol separations for people under 50 have varied and number less now than ten years ago.

**Figure 31:** Hospital separations by year for people 50+ years with a drug and alcohol-related diagnosis compared to people 0-49 years, over ten year period
Figure 32 demonstrates that the increase in drug and alcohol-related separations in the most recent three years can be attributed to both the ‘younger old’ and the ‘older old’ cohorts.

In Figure 33 it can be seen that drug and alcohol-related separations for all age groups 50+ have increased in the past 3 years. All age groups have seen increased drug and alcohol separations over the past 10 years with the exception of the 75-79 years age group.

**Figure 32:** Hospital separations by year for people 50+ years with a drug and alcohol-related diagnosis over 10 year period, by age cohort

**Figure 33:** NSW hospital separations with a drug and alcohol diagnosis by year, over ten year period, by 5 year age range
Where in the hospital are you most likely to see older people with substance-related issues?

For a full description of the bed type groupings, please refer to Appendix F: Data Definitions. It is of particular importance to note the following:

- There are no mental health bed types included in this data. Please refer to earlier parts of this report section for inpatient mental health data.
- Emergency bed types refer to admitted inpatient emergency beds, not Emergency Department contacts.
- The ‘aged care’ bed grouping relate predominantly to residential aged care facilities, not geriatric medical wards in the hospital.

Figure 34 demonstrates that people aged 50+ with a drug and alcohol diagnosis are most likely to be seen in multiple bed types prior to a hospital discharge. This supports the project themes regarding the need for better inter-sectoral relationships and collaborative models.

Figure 35 demonstrates that whilst the numbers of older people being admitted to drug and alcohol beds are relatively small, they are increasing. With a correlating decrease in admissions of people under 50, this may support the notion of ageing drug and alcohol treatment populations and the growing ‘younger old’ cohort numbers, with a long history of substance misuse and increasing ill health and ageing-related issues.

**Figure 34:** 2013-14 reporting year hospital separations with a drug and alcohol diagnosis, by age range and bed type

**Figure 35:** Separations with a drug and alcohol diagnosis by year, in the drug and alcohol bed type, by age cohorts, over ten year period
Figure 36 breaks down drug and alcohol bed separations for people 50+ into the two main cohorts, and further supports the increasing numbers of the ‘younger old’ cohort.

**Figure 36:** The separations for people aged 50+, in the **drug and alcohol bed type grouping**, by year, by age cohort, over ten year period

The following three figures (37, 38 and 39) demonstrate that whilst numbers are smaller in some other bed types, numbers of separations for people 50+ are higher than those for people under 50. This supports recommendations for drug and alcohol and mental health services to form good relationships and referral pathways across hospital services.

**Figure 37:** Separations with a drug and alcohol diagnosis, in the **medical bed type grouping**, by year, by age range, over ten year period
Figure 38: Separations with a drug and alcohol diagnosis, in the **rehabilitation bed type grouping**, by year, by age range, over ten year period

Figure 39: Separations with a drug and alcohol diagnosis, in the **multiple bed type grouping**, by year, by age range, over ten year period
Drugs of concern: What substances are the hospital separations related to for people aged 50+?

The following four figures (40-43) demonstrate that in line with the project themes, alcohol is the predominant drug of concern for people aged 50+ with a drug and alcohol diagnosis admitted to hospital. Tobacco represents a higher proportion of hospital separations than for mental health service utilisation, which is in line with its well-known causes of ill health and morbidities. Opioids represent a greater proportion of hospital separations for the ‘younger old’ than the ‘older old’ cohort, which is echoed in mental health service utilisation.

**Figure 40:** Separations by drugs of concern, by year, for people aged 50+, over ten year period

**Figure 41:** Separations by drugs of concern for the 2013-14 year, by age ranges
The following pie graphs (42 and 43) present hospital separations by proportion of drugs of concern for the key age cohorts.

**Figure 42:** Hospital separations by drugs of concern (proportion), people ages 50-64, 2013-14

**Figure 43:** Hospital separations by drugs of concern (proportion), people age 65+, 2013-14
Summary discussion, analysis and implications

**KEY MESSAGES: Service Utilisation Data Analysis**

The data supports key points that numbers of older people with substance use issues are increasing, that older people are already increasing their utilisation of NSW Health drug and alcohol and mental health services, and that these numbers are likely to keep increasing through generational change.

The primary substance related to older people’s service use is alcohol, and opioids are also significant. There are some changes in proportions and differences across service settings, but those two substances remain key priorities for services.

The hospital data confirms consultation advice and themes in the literature that indicate hospital settings provide an opportunity to improve screening and pathways to treatment for older people with substance use issues.

The NOPSAD and MSIC data (from page 23) demonstrates that whilst drug and alcohol and mental health services are not necessarily seeing them, there are older and ageing injecting drug users and treatment populations, and that pharmaceutical misuse is a key and growing issue.

The data supports the need for workforce development discussed in this report, both in the drug and alcohol and mental health workforce (particularly ambulatory) and in the hospital setting.

The drug and alcohol service utilisation data demonstrates a gradual increase in the age of those attending LHD drug and alcohol services, with increases in the number of services, particularly in the 50-64 age cohort. The drug types vary by age group, with alcohol, opioids and sedatives being on average the most prevalent for those aged 50+. Counselling, assessment and case management are the most common service types provided and residential/inpatient and non-residential/outpatient/community settings are the most common for service delivery.

As age increases, there is a marked reduction in the numbers of people who are seen in drug and alcohol services (see Figure 8). People aged 65+ make up a very low proportion of episodes of care (Figures 7 and 35). When they are seen, it is more likely to be in the context of general hospital inpatient settings rather than in outpatient settings or drug and alcohol beds (Figures 14, 15 and 35). There is a substantial increase since 2011 in those aged 65+ with a drug and alcohol diagnosis in medical, rehabilitation and multiple wards (Figures 37, 38 and 39) and most of this is due to alcohol (Figures 40 and 41). Yet, as a proportion of all those receiving care in drug and alcohol services, the broader target group of people aged 50+ represent a growing cohort of service users, with the number of service users under 50 decreasing. This is because there has been a substantial increase in the group aged 50-64 over the last 10 years, especially in 50-54 year olds (Figures 8 and 35). This pattern is also seen in mental health inpatient units (Figures 27, 28 and 29). This is being largely driven by increases in treatment for opioids, cannabinoids and cocaine (Figures 9, 10 and 11) and probably the ageing of the population generally. The data does not tell us whether changes are being driven by population increase in the baby boomer generation, or whether there is a cohort effect of different patterns of substance use, although the latter is implied and supported by the literature. It is still unclear whether the trends in the 50-64 year old cohort over the past decade will persist into the 65+ year old cohort, but this is likely to be the case.

There is an emerging trend for illicit drug use in older populations. This is new and is occurring across service delivery settings, and is a phenomenon that service providers, particularly those in SMHSOP services, have very little experience with. The data does not indicate whether these illicit drug users are new onset cases or chronic, ageing misusers. Information from the literature implies the latter, and the implications arising from this relate to managing comorbidities including premature ageing and cognitive impairment. It is as yet unknown what effect long term cannabis, hallucinogen, or opioid use has on the brain, including the type of OST prescribed. Despite the emerging illicit drug trend, alcohol remains the most prevalent substance in older age groups and so this should be a focus of concern.
For those in drug and alcohol services the drugs of concern are substantially different in the 50-64 age group compared with the 65+ age group. From the age of 65 there is currently virtually no use of cannabinoids, cocaine and opioids. This is likely to change as this group of users further ages. It is not clear from the data whether some of this population group ‘transition’ to age-specific/aged health services from the age of 65.

In mental health services there has been a significant increase in the number of clients with a drug and alcohol diagnosis who are 50 years or older. The biggest increase has been in those aged 50-59 years (Figures 19 and 20). The mental health service utilisation data suggests that relatively more of the 65+ age group with drug and alcohol diagnosis are seen in ambulatory than inpatient services. Whilst noting that inpatient data is less likely to change as markedly given the more fixed number of beds available, this suggests training on older people’s drug and alcohol issues should be targeted at SMHSOP and adult community teams.

The pattern of substance use is significantly different between those in drug and alcohol services and those in mental health services (Figures 21, 22, 9 and 11). Opioids account for 24-34% of those with a substance use diagnosis in mental health services but only for an average of 15% in drug and alcohol services. Sedative hypnotics account for only 1-2% in mental health services but 5-100% in drug and alcohol services. Note the 100% in 80+ year olds in drug and alcohol services probably represents only a small number of people and the relevant rates are 5-10% for 50-74 year olds. The pattern is different again in general hospital separations, with alcohol accounting for 55-70% of those with a drug and alcohol diagnosis.

Hospital utilisation data demonstrates that older people with drug and alcohol diagnoses are most likely to be seen either in multiple bed types prior to a hospital discharge, or across a variety of other bed types. This supports the project themes regarding better intersectoral relationships and collaborative models. It will be increasingly important for drug and alcohol services to have a strong presence in the medical/surgical wards and to start developing relationships with geriatric medical services. The Prince of Wales addiction medicine clinic (as per text box on page 69) demonstrates how older people may regard this style of service delivery in a general hospital setting as more suitable to their needs. It is important to note the data does not include community aged health services, and therefore there is no indication provided regarding how often home-based services might be required.

In broad terms, the data demonstrates that the impacts of increasing numbers/prevalence of older people with substance use issues, particularly the baby boomer generation, is mostly seen in adult mental health inpatient services, and drug and alcohol ambulatory services. The mental health service utilisation data suggests that relatively more of the 65+ age group with drug and alcohol diagnosis are seen in ambulatory than inpatient services.

In summary, the data supports key points that numbers of older people with substance use issues are increasing, that older people are already increasing their utilisation of NSW Health drug and alcohol and mental health services, and that these numbers are likely to keep increasing through generational change. The primary substance related to older people’s service use is alcohol, and opioids are also significant. There are some changes in proportions and differences across service settings, but those two substances remain key priorities for development of service response. Additionally, the hospital data confirms consultation advice and themes in the literature that indicate hospital settings provide an opportunity to improve screening and pathways to treatment for older people with substance use issues. Furthermore, the NOPSAD and MSIC data (from page 23) demonstrates that whilst our services are not necessarily seeing them, there are older and ageing injecting drug users and treatment populations, and that pharmaceuticals are a key and growing issue. The data supports the need for workforce development discussed in this report, both in the drug and alcohol and mental health workforce (particularly ambulatory) and in the hospital setting.
**Service access barriers**

### KEY MESSAGES: Barriers

Key service access barriers for older people with drug and alcohol issues reported in the literature and in project consultations are related to:

- recognition or lack of insight regarding the problem
- stigma and/or embarrassment
- availability of services
- lack of knowledge of drug and alcohol issues and services
- availability and affordability of substances
- ageism
- reliance on GPs for all medical advice, and
- a lack of established referral processes.

Literature reviewed in this project has indicated key service access barriers for older people with substance use issues include stigma and/or embarrassment, low recognition or lack of insight regarding the problem, ageism and under-recognition by health professionals, and accessibility of services themselves.

Research has shown those who perceive society as holding stigmatising beliefs about their condition are less likely to seek treatment than individuals who perceive society as being accepting of their condition (Conner & Rosen, 2008), and that stigma is one of the most pervasive barriers to seeking help (Doukas, 2011). A study on older methadone clients identified eight distinct stigma categories: drug addiction; ageing; taking psychotropic medications; depression; being on methadone maintenance; poverty; race; and HIV status, and found that clients who reported more stigmas were more likely to identify stigma as a barrier to substance abuse and mental health treatment (Conner & Rosen, 2008).

One study found that older people made assumptions that health professionals would interpret asking for medical help with other age-related symptoms as ‘merely seeking more medication’ and this prevented some people from getting adequate pain relief. There was a tension between fear of detox and fear of drug dependency in old age observed in this study (Ayres et al, 2012).

A further study found barriers to accessing treatment may include a reluctance to be associated with younger drug users and a sense of shame at ‘still using at this age’ (Ayres et al, 2012). Older people in the study mostly reported positive relationships with general practitioners (GPs) and shared care workers in respect of their drug use, but others had felt stigmatized and inadequately treated within Tier 4 (mainly hospital) services, which they attributed to their drug-user status (Ayres et al, 2012). In particular, older injecting drug users report experiencing discrimination more intensely than younger drug users, being judged as beyond help due to their advanced age (AIVL, 2011).

The Prince of Wales Hospital *Substance Use in Aged Care Study* included qualitative information from service users, and found that barriers to treatment were a lack of insight regarding the problem; embarrassment; lack of knowledge; availability and affordability of substances; often with no recognition of a problem, and a lack of action from GPs (Draper, 2013). Older people often do not ‘fit’ the model for standard adult treatment, and ageism, reliance on GPs for all medical advice and a lack of established referral processes were all considered to be barriers to care. Enablers were found to include good support and trust with the person’s medical provider, recognition of the problem by the GP, and support from employer regarding the time and cost of an intervention program. Possible solutions considered are combined community and hospital based programs including outreach, continuity of care, and GP education (Draper, 2013). The Australian Injecting and Illicit Drug Users League’s 2011 discussion paper on older injecting opioid users also notes that many older opioid users report great difficulties in accessing health and welfare services, in addition to experiencing greater disadvantage in relation to social determinants of health and physical health comorbidities (AIVL, 2011).

Lintzeris et al (2015) note that the delivery of OST does not accommodate the needs of ageing clients, with mobility problems creating issues with the treatment model that requires daily attendance at a clinic or pharmacy for supervised dosing (Lintzeris...
et al, 2015). Furthermore, those ageing OST clients who may need to transition to chronic pain medications, such as oral methadone, face considerable regulatory barriers (Lintzeris et al, 2015).

Evidence has supported the notion of under-recognition, with research demonstrating older people accessing health services were less likely to be asked about alcohol use, regardless of presenting symptoms indicating current use (Duru et al, 2010).

Barriers identified by stakeholders consulted in the project processes predominantly linked to the identified needs and key issues, with perceived barriers related to recognition, stigma, physical access and availability of services all commonly noted. Recognition and stigma are the primary barriers identified by stakeholders, including the elements noted above such as ageism, attitudinal barriers, and therapeutic nihilism. Stigma and shame can lead to reluctance to access established drug and alcohol services, with lack of anonymity attending services/clinics in regional areas a particular issue. Further barriers were identified related to poor experience, knowledge and understanding of staff, such as low rates of recognition of delirium in hospitals, issues with medication prescription management, limited understanding of the magnitude of the issues, limited skills in delivering services with older people, and minimal understanding of substance use issues in older patients by GPs. Additionally, the mixed age service design of drug and alcohol services makes assumptions about motivations for substance use which can differ for older people. All of these issues can act as additional barriers to access and service provision.

Limited understanding among health professionals of the range of services available and their referral systems was commonly raised as an issue. This barrier is included in the following workforce section. It is worthwhile noting that the consultation workshops brought together a range of stakeholders and thereby contributed to developing understanding among participants of relevant local services. The service mapping section of this report (from page 37, with full details included in the appendices) is also intended to promote understanding of some of the key services available for older people with substance use issues.

Other identified related barriers included difficulties with phone referral intake lines and the interface of paper and paperless systems. The varying age criteria for services also contribute to difficulties experienced. In particular, there are issues in accessing aged care services by the ‘younger old’ cohort. These people may be aged between 50 and 65 and experience premature ageing issues such as cognitive impairment, a multitude of physical health comorbidities, and reduced ability to independently manage activities of daily living, with a subsequent need for community or residential aged care. Whilst there is no lower age cut-off in the Aged Care Act, in practice it can be difficult for people to access these services under the age of 65 or 70.

The consultations also raised issues related to carer involvement. Mental health carer representatives noted the lack of carer engagement in drug and alcohol service model can be a barrier, but it was also noted that carer presence can be a barrier to disclosure/access of services in hospital due to stigma and/or shame issues.

Further barriers can exist for Aboriginal families, who often deal with their drug and alcohol and/or health problems within families, rather than seeking support from services. Additional cultural and language barriers exist for CALD communities, and little is known regarding the intersection of age, culture and substance use.

Other barriers identified by stakeholders included resources and staffing being insufficient, and transport and physical access as noted in the ‘key issues’ section from page 34. Additionally, stakeholders identified that the traditional approach or service design of drug and alcohol services, being a voluntary model that relies on a potential client presenting to the service seeking change, may in itself act as a barrier for older people. This is due to issues with isolation, recognition, stigma and physical access.
Drug and alcohol and mental health workforce issues

KEY MESSAGES: Drug and alcohol and mental health workforce

The drug and alcohol workforce will need to build their skills and understanding of ageing-specific issues. These include issues related to physical and mental health issues in older people and cognition, among others.

The mental health workforce will need to be able to conduct drug and alcohol screens, assessments and brief interventions, and be able to refer to and collaborate with drug and alcohol services when required.

A range of workforce-related issues were raised by consulted stakeholders. Older people with substance use issues are emerging as a key group, and this presents challenges that will require a workforce development response, as well as a service delivery and development response.

Responses to consultation questions regarding gaps in knowledge and workforce development issues generally highlighted the need for key services to have a better understanding of available services, and better understanding of older people with substance use issues and their needs. Key stakeholders and consultation participants consistently identified a gap in their knowledge of services relevant to older people with substance use issues, as well as their roles, functions, target groups and referral pathways. Some services reported actually being able to offer age appropriate care, such as home visits, but not considering the importance of this for older consumers. Given the need for improving appropriate referral of older people with drug and alcohol issues and inter-sectoral collaboration, this is a key issue to be addressed.

Stakeholders identified issues related to poor experience, knowledge and understanding of staff from across sectors with regards to substance use issues in older people. Low rates of recognition of delirium in hospitals, issues with medication prescription management, limited understanding of the magnitude of the issues relevant to older people with substance use issues, limited drug and alcohol staff skills in delivering services with older people, and minimal understanding of substance use in older patients by GPs were all cited as workforce-related issues. Additionally, the mixed age drug and alcohol service design makes assumptions about motivations for substance use, which can differ for older people.

Stakeholders reported key areas for consideration in addressing the knowledge gaps among the workforce-related to the training and development needs of drug and alcohol staff, mental health staff, and other health workforce members, as follows:

- **Drug and alcohol workforce**: understanding ageing specific issues, which include falls and falls risk; conducting cognitive screening and assessment; being able to engage older people using their own goals, which might include hospital avoidance or harm minimisation; and knowing how to engage, assess and provide services for clients who have cognitive impairment. Trauma informed care, and developing workforce capacity to identify and address separate elements such as pain and depression were further specific suggestions.

- **Mental health workforce**: There is a need for the adult and older people’s mental health workforce to be able to conduct drug and alcohol screens, assessments and brief interventions, and be able to refer to and collaborate with drug and alcohol services when required.

- **Other health workforce sectors**: Needs to consider might include training staff from aged care, aged health, and primary care in drug and alcohol screening and assessment, and referral to and collaboration with drug and alcohol services when required.
Referral and interface issues

KEY MESSAGES: Referral and interface issues

A key issue in this project relates to integration of and collaboration between services and sectors, particularly drug and alcohol services, mental health services, aged health or hospital services, and primary care.

Hospital-based services and the drug and alcohol consultation liaison (DACL) role can be important in referral of and access to drug and alcohol services for older people with drug and alcohol issues.

Whilst older people with substance use disorders may have limited family support, if there is a family member or carer involved, often referral pathways are more easily navigated and referrals more successful.

A key issue in this project relates to integration of and collaboration between services and sectors, particularly drug and alcohol services, mental health services, aged health or hospital services, and primary care. Consulted stakeholders were asked for comment on issues related to referral pathways and service interfaces. Some good collaboration and referral relationships between key services such as drug and alcohol services and GPs, aged care and mental health services was reported, but this was based on good local relationships rather than established partnerships or protocols. The siloing of drug and alcohol services was commonly cited, and stakeholders noted co-location or even being situated in the same building can help integration between drug and alcohol services and other health services. The ‘no wrong door’ policy is often not consistently implemented in practice. As noted in earlier sections, the different sectors often have a poor knowledge of the other’s intake systems. A lack of ownership or follow through with the client (particularly reported with dual diagnosis) was also noted as a problem.

Hospital-based services and the DACL role can be important in referral of and access to drug and alcohol services for older people with substance use issues. When consumers are in hospital, stakeholders reported engagement in services is often better, noting the DACL role as instrumental in this. Hospital social workers were also identified as important, along with good relationships with Aged Care Assessment Teams (ACATs). It was noted that aged care workers in Aboriginal Medical Services don’t currently specifically deal with substance use issues, but may be a useful access point for older people to drug and alcohol services/treatment.

Access to appropriate services is limited and impacts on referral pathways. Issues were raised in relation to poor access to neuropsychology assessment outside of Sydney, where alternative services need to be accessed; and systemic issues with requiring certain (difficult to access) assessments before admission to a service. Inner city stakeholders reported there is inadequate staffing for follow up post discharge for a withdrawal admission, which can result in transitional homelessness prior to going to residential rehabilitation services.

Having a good relationship with the public guardian was seen as important by stakeholders, and the consulted public guardian representatives noted that in general the Office of the Public Guardian and relevant services work well together. Issues can arise when the NSW Public Guardian is engaged to assist in decision making, but there are not appropriate services or accommodation options available for the person.

Issues regarding risk in services can be a limitation in referral and accessing services for substance using populations. Risk tolerance thresholds vary, but can be seen as a black and white issue for some services, and this results in exclusion of some clients.

Issues reported by stakeholders related to carer involvement were described in the ‘barriers’ section above. Additionally, it was reported that whilst older people with substance use disorders may have limited family support, if there is a family member or carer involved, often referral pathways are more easily navigated and referrals more successful. The standard practice in drug and alcohol services is carrying out individual assessment, and stakeholders noted this can be disengaging for families. The challenge is to find a balance between engaging families and protecting consumer rights to privacy, and minimising the risk of under-disclosure through stigma and shame in carers’ presence.
Case vignette 3: Referral issues and service design

Case vignette: ‘Ms D’

Ms D was a 60 year old woman who used Xanax, and had underlying anxiety and sleep issues, in combination with fixation of thoughts that might have been related to decline in cognitive function.

Ms D was asked by her GP to see drug and alcohol services. Upon presenting it became evident Ms D did not realise that this referral meant having a treatment goal of benzodiazepine reduction (ultimately leading to abstinence). She declined to see drug and alcohol services further and rejected the notion that she was dependent on a substance.

Ms D would have benefited from better informed treatment goals through her GP, and an integrated one-stop shop approach that included the availability of psychiatry and neuropsychology on site in the drug and alcohol service.

Clinical processes and service delivery arrangements that work

KEY MESSAGES: Clinical processes and service delivery arrangements that work

There is a need for improved liaison and stronger collaborative models to be developed and implemented between aged or general health services, primary care and mental health and drug and alcohol services.

Practical barriers should be addressed (e.g. by providing home visits), and older people’s co-existing physical health needs should be considered an integral part of their overall management.

Although older adults generally have equivalent outcomes to younger cohorts in mixed aged treatment studies, if treatments are adjusted for older people, they may be more effective and improve outcomes in comparison to mixed age treatments.

Many older people with drug and alcohol issues have complex care needs and require a case management approach, with carer involvement and support where possible, as well as acknowledgement of the client’s own potential caring roles.

‘One stop shop’ approaches can improve accessibility for people with complex comorbidities or issues, and bring holistic and multidisciplinary care to the person within one appointment.

Few Australian drug and alcohol services cater specifically for the needs of older people, and existing mixed aged services may not be age-appropriate for older people. For example, there are limitations of office-based care delivery systems and difficulties of access for people with mobility problems.

A number of recent studies and reports from Australia, the UK and the US have highlighted the need to adapt service delivery models and clinical processes to respond to the needs of the emerging population of older people with substance use issues. The strongest theme arising is the need for improved liaison and stronger collaborative models to be developed and implemented between aged or general health services, primary care and mental health and drug and alcohol services (Draper, 2013; McGrath et al, 2005; Lintzeris et al, 2015; RCPsych, 2011; Shaw & Palattiyil, 2008). Further key themes and recommendations are that practical barriers should be addressed, commonly through home visits (McKay, 2013; Shaw & Palattiyil, 2008) and that older people’s co-existing physical health needs should be considered an important part of management (McGrath et al, 2005; McKay, 2013; Lintzeris et al, 2015).

The Royal College of Psychiatrists expands on the collaborative service design recommendation by specifying that local policies should be developed on the basis of need; elimination of age barriers; easy transfer between services; joint working arrangements; clear decisions regarding who will be the lead service; as well as protocols regarding admission (RCPsych, 2011).

Spencer (2001) outlines some key principles for working with older people with substance misuse issues, which are relevant to the provision of interventions and this project. These principles include:

- being client centred
- orienting the goals of treatment to reducing the person’s distress and improving or maintaining function and as much independence as possible
- being accessible and flexible
- being comprehensive (taking into account all of their needs and working with other agencies to meet those needs)
- providing specific services that recognise the different needs between older people and younger adults who have alcohol problems and designing the services that are appropriate and relevant to them, and
- being accountable – to the client, families and those providing the services (Spencer, 2001).

Studies reviewed in Keurbis & Sacco (2013) suggest that age-specific treatments may work better for older people. Although older adults generally have equivalent outcomes to younger cohorts in mixed aged treatment studies, if treatments were adjusted for older people, they may be more efficient and improve outcomes in comparison to mixed age treatments. The age-specific components were:
- an emphasis on building relationships and support
- less confrontation, and
- older adult-only environment.

Although treatment attributes or mechanisms were not investigated, the findings suggest that older people in age-specific programs were more likely to stay and complete treatment, have fewer irregular discharges, and are more likely to have successfully treated relapses (Keurbis & Sacco, 2013).

The following boxes contain an example of an Australian service designed specifically for older people, and a NSW service example of a clinic that was not targeted specifically to older people but through its service design has catered to the needs of older people and subsequently had a higher proportion of older people than expected.

Service example 1

**The OWL Program**

The Older Wiser Lifestyles (OWL) program is based in Peninsula Health in Victoria. This program has a preventative/early intervention component focussing on older people and alcohol misuse, and a treatment component encompassing other substances and medication misuse.

The early intervention component centres around the target population completing the Australian Alcohol Related Problems Survey (A-ARPS) and strategies to facilitate this, such as staff members presenting at community organisations, older volunteers taking iPads loaded with the screening tool around hospitals, and the iPads being used at GP clinics in waiting rooms. Links to brief interventions and treatment are offered as indicated after screening.

The treatment program component consists of a more flexible and assertive service model than traditional mixed age services, offering a slower pace as required, and home visits for appointments. One of the strategies used in the treatment component of the program to address cognitive changes is a DVD for consumers that summarises the advice and strategies provided.

Service example 2

**Prince of Wales Hospital Addiction Medicine Clinic**

The Prince of Wales Hospital Addiction Medicine Clinic was initiated to address a gap in service provision for patients being discharged from hospital with a substance use issue, who may not be able to or be inclined to attend existing community drug and alcohol services. The clinic is not specifically for older people. However, the outpatient clinic environment has suited older people, especially when already engaged in hospital environment through admission, and has met the identified gap in services for that population. The average age of the clinic’s clients is now 50-75 years old.

Referrals to the clinic come from various teams within the hospital including the emergency department. The clinic is held weekly in the outpatients department and is staffed by two Clinical Nurse Consultants/staff specialists. The majority of clients are referred to the clinic for issues with alcohol, and clients tend to have multiple comorbidities. There is no specified upper limit to number of appointments clients can attend, although the service is designed for brief interventions with referral on to specialist services as required, for example for full cognitive assessment, or full psychiatric assessment and intervention. The clinic staff offer liaison and referral with a number of key partners including GPs, drug and alcohol community services, the pain clinic, mental health services, and the aged care assessment team.
Service design issues reported by stakeholders in project consultation reflected many of the key points in the literature. It was particularly highlighted that many older people with substance use issues have complex care needs and require a case management approach, with carer involvement and support where possible, and acknowledgement of the client’s own potential caring roles (noting that consumer and carer rights and benefits needs to be acknowledged). Strategies to support problem solving or addressing barriers to care and successful treatment are important components of a complex care approach. This is supported by Lintzeris et al (2015) who identify that the high rates of health service utilisation by most of the participating older clients of drug and alcohol services, and the diversity of health and social problems indicate that a care coordination or case management approach may be better suited for many clients (Lintzeris et al, 2015). Decision making support and involuntary treatment options were identified by consulted stakeholders as needs for clients with a long history of substance abuse and/or cognitive impairment.

Regarding integrated services and better inter-sectoral understanding, stakeholders identified ‘one stop shop’ approaches can improve accessibility for people with complex comorbidities or issues being able to organise multiple care pathways, and bring holistic and multidisciplinary care to the person within one appointment. At a broader level, it was suggested that aged health, mental health, and drug and alcohol services should improve their understanding of each other’s services and develop more collaborative approaches. This may involve in-service training, secondments, interagency meetings, attending each other’s team and/or clinical meetings, an agreement to collaborate, embedding drug and alcohol clinicians within mental health assertive outreach teams (as per successful experiences with Homeless Health), better partnerships, and services examining service eligibility criteria and removing any unnecessary restrictions on service eligibility.

In addition to integrated or one stop shop services, stakeholders felt targeted approaches for older people are needed, such as: 1) age-specific therapy groups to address general ageing, cognitive issues and social needs; 2) inclusion of age-specific withdrawal support, and 3) appropriate service delivery approaches such as providing outreach and home visiting.

Assertive outreach or engagement models have not been the traditional approach of the drug and alcohol sector, but stakeholders identified they would be beneficial for older people with substance use issues. Consultation participants reported that services need to be more proactive about identifying this population and promoting service access and engagement, rather than relying on older people to present to services.

Consultation participants suggested a number of service improvement and service development strategies related to supporting appropriate transitions and transfer of care between services. Suggestions included use of existing short term care packages on discharge from hospital to address certain substance use issues; a Community Treatment Order (CTO) type option post-IDAT or residential rehabilitation discharge; and to align rehabilitation admission immediately post-discharge from a withdrawal admission to avoid a gap in service provision at a vulnerable time, which can result in relapses and homelessness.

Further to the need for better service design and service integration to address the needs of all substance using older people, there are particular points of consideration for older Aboriginal people and older people from CALD backgrounds.

Good practice in identifying, engaging and retaining older people from Aboriginal and CALD backgrounds with substance use issues is likely to reflect principles across age ranges, such as budgeting for and quality use of interpreters; carrying out skills audits and workforce development to address cultural competency; creating partnerships and relationships with external services and community groups (such as Aboriginal Community Controlled Health Services and ethnopspecific agencies) to improve referral pathways; acknowledging family and community as principles of service planning and delivery, and benchmarking regarding how services engage with and provide services for Aboriginal and CALD clients.

Particular strategies relevant to older people have also been identified. Aged care workers in Aboriginal Medical Services may be a potential access point in the system for older Aboriginal people, if those workers are engaged and provided with education and appropriate screening tools. Additionally, trauma informed care, recognising potential trauma experienced by older Aboriginal people in relation to the Stolen Generations, or in relation to the migration/refugee experience of older people from CALD backgrounds and how this
Examples include the following practices in NSW:

- In the context of service provision for clients with dual diagnosis, local services in the Central Coast noted improved practice with supporting Aboriginal clients. This may be attributed to involvement of the Aboriginal Health Worker improving integration and collaboration, and providing a case management approach.

- At Westmead Hospital, a disability assessment tool (that incorporates functional decline associated with ageing) is used to determine eligibility for takeaway privileges and home dosing, both of which may be more suitable for some older clients of the service. Also at Westmead, a ‘one stop shop’ clinic delivers drug and alcohol services alongside neuropsychology, psychiatry registrar services, and physical health care, all at one outpatient clinic. A further integrated clinic at Westmead, the ‘alcohol clinic’, caters for osteoporosis, liver health, cognitive decline, and psychological intervention whilst addressing needs related to alcohol. This is supported by the findings on integrated care delivery in the randomised controlled trial (RCT) cited on page 77.

- The Mt Druitt community drug and alcohol team provide an outreach clinic at the local Men’s Shed and at a local church. These clinics were developed in response to the target population not being able to access the team location at Mt Druitt shops. Some older people and many Aboriginal people attend the clinics. This is an example of flexible service design addressing target population needs.

- DACL positions were described across different settings as providing early support and investigation in the hospital setting, and helping cross-sectoral teams to consider the drug and alcohol perspectives in a complex case, as well as providing referral to drug and alcohol services and support. For some older people with substance use issues who are not engaged in formal services, but present with a variety of acute and/or chronic complaints to a range of hospital services, the DACL clinician or service may be the most commonly seen health professional and have the best relationship or history with the person in the hospital system.

- The South Eastern Sydney LHD Prince of Wales Hospital Addiction Medicine Clinic is highlighted in the text box on page 69. Another South East Sydney LHD drug and alcohol service initiative highlighted is the screening of all indicated patients for cognitive impairment. Once screened, people are referred into old age psychiatry pathways if required. The data is not yet available on outcomes. Referrals specifically focus on cognitive comorbidities. The physical location is a positive component; being co-located with existing services and being physically suitable for older people. A key (and transferrable) feature is that the drug and alcohol, aged health, and SMHSOP services have been collaborating, with regular meetings to build care pathways and to organise staff education, including well attended joint training days.

- The IDAT program model was discussed by the EAG and at the Orange consultation, noting that a large proportion of this program’s patient group are 50 years and over, with identified symptoms of cognitive impairment. This service was not designed for older people, but is now having to meet the needs of its older treatment population. The service provides a holistic and empowering approach based on motivational interviewing strategies, and incorporating physical health assessments, care and education. A strong focus on practical discharge preparation and problem solving is reported to increase successful discharge to community living for older people with cognitive impairment. Physical access has been a barrier to older mobility-impaired people being able to be accepted at one of the sites.

Rural and regional examples of good practice identified included the following two cases:

- On the NSW North Coast, an older Aboriginal man in his mid fifties, who experienced physical and cognitive impairments secondary to alcohol abuse was able to participate in an Aboriginal community controlled residential rehabilitation program when relevant stakeholders collaborated and arranged for his mental health Housing and Support Initiative (HASI) package to be delivered on site at the rehabilitation centre. His HASI package included supporting him with his activities of daily living, including showering and personal care needs, which rehabilitation staff did not support. Due to the collaboration and flexible service provision this consumer was able to participate for two months in the rehabilitation program for alcohol abuse, in a culturally safe program.
In Western NSW LHD, the sub-acute care team implemented a hub and spoke model, based out of Orange Health Service. It followed complex older patients from the regional hospital where they were admitted, to their more rural localities in an integrated way on discharge. The service included addressing drug and alcohol needs when present in the complex case mix and working with residential aged care facilities to negotiate appropriate service access and care.

Homeless people and people at risk of becoming homeless are a particularly vulnerable sub-group of the target population. Consulted stakeholders from the Inner City Health Networks NGO Partnership Network demonstrated good intersectoral networking and support to meet the needs of this population, and highlighted good practice among NGOs and public services in the area. Mercy Arms is a supported accommodation service that has demonstrated good outcomes in providing further transition support from the St Vincent's homeless health service. Charles Chambers Court and Matthew Talbot Hostel are both accommodation options commonly catering to the needs of older people with substance use issues.

Another sub-group of the target population are older people in the criminal justice system. Consultation with NSW Justice Health and the Forensic Mental Health Network highlighted that the Connections program for offenders has demonstrated success in providing support following release from custody and assisting in reintegration into community living for older people with substance use issues. The program is not targeted for older people, but has a holistic and person-centred approach encompassing a variety of daily living support and reablement needs, which makes it relevant for older people with a history of substance use issues.
PART B: CLINICAL PRACTICE

Screening and assessment

KEY MESSAGES: Screening and assessment

A screening test should be used as the first step in a process that should involve screening, brief intervention, and referral to treatment (for comprehensive assessment and formal diagnosis), according to screen outcomes and service setting.

Existing screening instruments may not be appropriate for older people and screening instruments for prescription drug abuse have not been validated in the geriatric population.

The Alcohol Use Disorders Identification Test (AUDIT) has been found to have low sensitivity among older adults, although this improves with lowered cut off points. As a brief screening measure, the 3-item AUDIT-C has been validated as a sensitive tool, notwithstanding the same variance in findings regarding cut offs most relevant to older people.

The Alcohol, Smoking and Substance Involvement Screening Test (ASSIST) is a validated screening tool for alcohol and other substances. It also has not been validated in older populations, although it has been used in pilot programs and studies in NSW with older people without obvious difficulties.

The Indigenous Risk Impact Screen (IRIS) is a screening tool for alcohol and other drug issues (and mental health issues) developed and validated for use with Aboriginal people.

Screening for cognitive impairment is another important component of clinical practice. There are a multitude of cognitive screens available, and local consistency with referral partners is important.

Drug and alcohol and mental health services should have in place processes for falls risk screening, and either assessment and management or referral for intervention.

As mentioned previously in this report, recognition of substance use problems in older people is low. American research highlights that the oldest groups are the least likely to be asked about alcohol use regardless of the presence of coexisting risk factors (Duru et al, 2002). In this context, screening is an important component of improving responses to the target population. Comprehensive assessment is also important, especially when the older person may receive symptomatic treatment (such as sedative hypnotics for sleep problems) instead of intervention targeting the full range of symptoms (Wang & Adnrade, 2013).

Consultation processes revealed many services and clinicians felt there was a lack of appropriate tools and processes in place for screening and assessment. It was also felt that there is a need for identification and training of appropriate staff in the clinical pathway to conduct screening and assessment with the target population. The need for tools for identifying risk and risk management strategies was highlighted, particularly with regards to the ‘younger old’ cohort. The importance of holistic and comprehensive assessment was also emphasised by stakeholders.

The US Substance Abuse and Mental Health Services Administration Guidelines recommend that a screening test be used as the first step in a process that should involve screening, brief intervention, and referral to treatment, according to screen outcomes (Naegle, 2012). This approach is widely supported in the literature for use in primary care and general health care settings.

The US Treatment Improvement Protocol Services (TIPS) No 26 on Substance Abuse Among Older Adults (US Department of Health & Human Services, 1998) recommends that anyone who is concerned about an older person’s drinking practices should ask direct questions (Spencer, 2001). TIPS also recommends that every 60 year old should be screened for alcohol and drug abuse as part of his or her physical examination, as do the UK Royal College of Psychiatrists, The United States Preventive Services Task Force, and studies related to medical settings, primary care setting, and mental health settings (Matthews & Oslin, 2009, McGrath et al, 2005; Naegle, 2012).
Other published articles from Australian research support the notion of routine screening. Taylor, Jones and Dening (2014) note that the incidence of alcohol use disorders in older adults is high enough to justify routine enquiry particularly when the increased susceptibilities are factored in. Additionally, Draper et al (2015) found that although many patients in aged health services have risky alcohol use, there are few clinical features to distinguish them from other patients due to the level of comorbidity in existence. They too recommended routine screening for alcohol and substance use (Draper et al, 2015).

A range of screening tools are available and are summarised in the following paragraphs. It is important to note however, that existing screening instruments may not be appropriate for older people (Wang & Adnrade, 2013) and screening instruments for prescription drug abuse have not been validated in the geriatric population (Culberson & Ziska, 2008). Additionally, Australian research has demonstrated that older people tend to pour drinks that are larger than a standard drink (as do younger people) (Wilkinson et al, 2011) which affects the validity of self report measures.

With regards to alcohol screening tools, the Alcohol Use Disorders Identification Test (AUDIT) (Saunders et al, 1993) was developed by the World Health Organisation as the gold standard screen for hazardous and harmful alcohol use. It has been found in a systematic review of the literature to consistently have low sensitivity among older adult populations, likely due to not taking into account medications, medical history, and functional status (Bright et al, 2013). However, the AUDIT has been found to be an accurate screening tool when the cut off points were lowered and tailored to levels relevant to older adults (Aalto et al, 2011; Draper et al, 2015). Supporting this, a number of studies found differing cut off points to be the most appropriate options for use with older populations (Aalto et al, 2001; Berks & McCormick, 2008; Draper et al, 2015). As a brief screening measure, the 3-item AUDIT-C, comprising the consumption questions of the AUDIT, has been validated as a sensitive tool (Bush et al, 1998), notwithstanding the same variance in findings regarding cut offs most relevant to older people.

Alongside the AUDIT, other alcohol screening alternatives include the Alcohol Related Problem Survey (ARPS), the Cut down, Annoyed, Guilty, Eye-Opener Test (CAGE), and the Michigan Alcohol Screening Test (MAST) or its shorter version targeted for older people, the SMAST-G. The CAGE, AUDIT and SMAST-G have been successfully used with older people (Wang & Adnrade, 2013). However, there is the risk that ‘problematic’ or ‘risky’ drinking use may go undiagnosed using existing screening tools, due to the safe level of consumption for younger people indicated in the screens not being appropriate for older people (Hunter & Lubman, 2010). Continued use of these screens without using lower cut offs will lead to the continuing under-detection of alcohol use problems in older people (O’Connell et al, 2004).

It has been suggested that the ARPS provides the best assessment of problematic alcohol use in this age group (Hunter & Lubman, 2010), although is currently only available online. Research in Victoria has resulted in the ARPS being recalibrated for use in Australia (and other countries with standard drinks containing 10g of ethanol) as the A-ARPS. The researchers report that it considers alcohol consumption within the context of age-specific factors that increase the risk of an older adult experiencing alcohol-related harm (Bright et al, 2013). However, it is also only available online at the present time.

The Alcohol, Smoking and Substance Involvement Screening Test (ASSIST) was developed by the WHO and is a validated screening tool for alcohol and other substances (Humeniuk et al, 2010). It also has not been validated in older populations, although it has been used in pilot programs and studies in NSW with older people without obvious difficulties (Draper et al, 2015).

The Indigenous Risk Impact Screen (IRIS) is a screening tool for alcohol and other drug issues (and mental health issues) developed and validated for use with Aboriginal people, and promoted to the Aboriginal Drug and Alcohol Network (ADAN) members by the NSW AH&MRC. The mean age of the sample used to validate the tool was 35 (Schlesinger et al, 2007) and it has not been researched for use with older Aboriginal people. It is recommended to consider the use of this tool with older Aboriginal clients, and be guided by collaborating local Aboriginal workers from across sectors regarding appropriate assessment processes.

Screening for cognitive impairment is another important component of clinical practice, in light of the prevalence of cognitive impairment discussed in earlier sections of this report. The Royal College of Psychiatrists recommends screening for cognitive functioning using the Mini Mental State Exam.
Another emerging issue that may be more pertinent for drug and alcohol services as they start to see more of the target population is the issue of falls risk. Drug and alcohol and mental health services should have in place processes for falls risk screening, and either assessment and management or referral for intervention, in line with the ACSQHC National Safety and Quality Health Service Standard (NSQHSS) 10: Preventing Falls and Harm From Falls.

Consulted stakeholders also identified that, in light of physical access barriers, Hospital in the Home (HITH) services are an important consideration with regards to screening and assessment - both for eligibility for these services, and also regarding safety and risk issues. HITH services deliver selected types of patient-centred multidisciplinary acute care to suitable, consenting patients at their home or clinic setting as an alternative to inpatient (hospital) care. A thorough assessment is required for clear identification of potential clients suitability for HITH, as there are risks regarding non-disclosure, social isolation, and polypharmacy that may not provide an accurate insight of current substance use levels. Following referral, the HITH service should ensure patient agreement and registration processes are complete. The NSW Health Guideline GL2013_006 NSW Hospital In the Home (HITH) Guideline includes the requirement that a local risk assessment process be undertaken at the time of referral to the servicers which includes: clinical risk; physical environment of the home; aggression risk from patient and/or others; manual handling risks; utilisation/effectiveness of communication devices; drug and alcohol concerns including smoking in the home; and non-clinical support required (NSW Health, 2014).
There is a paucity of research evidence nationally and internationally on specific best practice approaches and service models for the target population. There are several papers related to one multisite RCT conducted in the US, the Primary Care Research in Substance Abuse and Mental Health for the Elderly (PRISM-E) study, and most of the RCTs identified for review in Keurbis & Sacco (2013) and Kok (2014) relate to alcohol, and are limited by small sample sizes. There is, however, a growing awareness of the need to develop improved responses, and professional opinion reports from respected sources are growing, such as that from the UK Royal College of Psychiatrists (2011). Crome and Crome (2005) highlight that services and intervention for older people need to include modified strategies and delivery methods such as age-specific settings, flexibility, and a holistic approach incorporating psychological, physical and social needs. Substance use programs for older adults may require a wider range of treatments, and alternative treatments to those that are used currently (Gossop & Moos, 2008). Programs for older adults should be able to provide basic-level medical services and, where severe or complex health problems are identified, to provide referral to specialist medical services.

Consultation processes highlighted that more effective use of non-pharmacological and allied health in pain management is desirable to address issues surrounding pain and prescription medication. It was also suggested that family-centred care and trauma-informed care were needed for Aboriginal people in using drug and alcohol services.

The available evidence is summarised by themes below. It is important to note that many of the studies reviewed relate to alcohol use and treatment only, and also relate to older adults who were seeking treatment. Further work needs to be carried out regarding accessing those older people who are not seeking treatment or harm reduction education, to address the issue of low recognition. In addition, there has only been one study looking at people with a very late onset of alcohol use, and it is not known if these older people have a different prognosis or need different treatments tailored to the aetiologies of their alcohol use disorder (Kok, 2014).

Keurbis and Sacco (2013) found 25 studies for review, and classified them in to three groups: 1) Ten studies examining mixed age/non-age-specific treatments applied to older adults; 2) 13 studies highlighting treatments specifically for older adults – including traditional treatments that were used in an age-specific setting or with a homogenous group of older adults; and 3) Two studies directly comparing the above types of treatments.

**Mixed age treatments**

Keurbis and Sacco (2013) summarise the results of the ten studies describing mixed age treatments as consistently demonstrating older adults responding equivalently well to younger cohorts to the mixed age treatments. Regardless of modality, more treatment through longer length of stay or treatment adherence results in better outcomes for older people. Brief interventions were found to positively impact older adults’ drinking. In terms of which mixed-age treatments were most effective, there was little to demonstrate what the most important components are for older people. Chemical aversive counter-conditioning to alcohol, cognitive behaviour therapy (CBT), and relationship enhancement therapy all demonstrated positive outcomes for older people. However, as the studies did not contain true control groups it cannot be definitely concluded what outcomes can be attributed to the treatment (Keurbis & Sacco, 2013).
Another study found that in general, older patients have positive views of age-integrated treatment programs (Gossop & Moos, 2008). The authors reported that older patients generally engage well with treatment and achieve equivalent or better outcomes than younger adults in age-integrated treatment programs. Once identified, older adults' substance misuse problems can be treated effectively, and these individuals can recover and maintain an improved quality of life. To achieve this goal, health care providers are likely to need specific training to learn how to recognize and address these problems among older adults (Gossop & Moos, 2005).

**Age-specific treatments**

The thirteen studies reviewed by Keurbis & Sacco (2013) generally demonstrated positive outcomes for older people, even with minimal intervention, both at end of treatment and at follow up. Similarly to the mixed age treatment results, this initial evidence suggests better outcomes related to more treatment for older people. Age-specific treatments in the studies comprised mostly of tailoring information to the age group (such as education about unique medical vulnerabilities to alcohol and combining medications). Physical adaptations to treatment included disabled access or a slow pace of treatment. Psychosocial adaptations to treatment included group therapy with topics relevant to life stage, such as coping with loss, grief, loneliness and life transitions (Keurbis & Sacco, 2013).

**Integrated care vs. specialist drug and alcohol/mental health referral**

The PRISM-E trial involved screening older adults for alcohol use, and randomising older at risk alcohol users to either integrated primary care intervention (brief intervention session provided onsite at the primary care clinic by a substance use worker), or referral to a specialist provider (referral to an offsite speciality mental health or substance abuse clinic). Alcohol users who received the integrated care were twice as likely to stay in treatment (average 1.42 visits vs. 0.78 visits), and treatment engagement was greater for those with more severe problems (Keurbis & Sacco, 2013). Engagement among the referred group remained lower than the integrated care group, even when the referral was made to a service in the same location (Bartels, Coakley, & Zubritsky, 2004). This is consistent with findings locally where integrated care clinics located in primary care locations have been found to increase access by older people. Results from the PRISM-E study demonstrate significant reductions in both quantity and frequency of drinking and binge drinking over six months for both treatment models. However, there were no differences in drinking outcomes between the two treatment models at six months (Oslin et al, 2006).

Lee et al (2009) found that individual, medically-oriented and integrated care with a harm reduction approach was more effective in reducing the number of drinks and the number of binge-drinking occurrences than community-based group programs using the 12-step model of total abstinence (Lee et al, 2009; Kok, 2014).

**Comparison of mixed age and age-specific treatments**

Both of the two studies directly comparing mixed-age and age-specific treatments utilised samples from veteran populations. Whilst there are only the two studies and results may not be generalizable to broader population groups, results suggest that age-specific treatments may work better for older people than mixed age treatments (Keurbis & Sacco, 2013). The age-specific components were:

- an emphasis on building relationships and support
- less confrontation, and
- older adult-only environment.

**Brief intervention**

Brief intervention involves interaction with a health care provider which includes more than the provision of information, and has been found to be effective for people with less severe alcohol problems and also to motivate those with more severe problems to seek specialised treatment (Hunter & Lublam, 2010). Brief interventions by health care providers following positive screening of older people who are drinking at high levels have been shown to be useful in reducing alcohol consumption (Christensen et al, 2006; Naegle, 2012).

- A study reviewed by Keurbis and Sacco looked at effectiveness of brief interventions for hazardous drinking in all ages in a primary care setting and randomised participants to one of three conditions (motivational engagement, brief advice or standard care). All three groups significantly decreased use of alcohol and trends were found for motivational enhancement and brief advice decreasing alcohol consumption over standard care (Keurbis & Sacco, 2013).

- Keurbis and Sacco also reviewed studies on age-specific brief interventions. One of the studies involved counsellors providing a health promotion
workbook and utilising techniques of motivational interviewing. Among those who screened positive for alcohol use, there were significant reductions in the proportions of individuals experiencing alcohol problems and symptoms of alcohol dependence (Keurbis & Sacco, 2013). The participants also reported reduced prescription medication misuse and use of over the counter medication. It should be noted that the program also involved frequent in-home contact with staff (Keurbis & Sacco, 2013).

An RCT was completed to examine the effectiveness of brief intervention via 1) provision of a general health booklet or 2) personal feedback booklet on the participants drinking and a scheduled primary care visit with their physician that included a contract to reduce drinking (Keurbis & Sacco, 2013). At follow up the latter group had significantly fewer drinks in the previous seven days, fewer binge episodes and less excessive drinking. Similar studies looked at provision of a general health booklet versus personal feedback and a drinking diary, of which the intervention group had fewer at risk drinkers, reporting less heavy drinking and fewer drinks at three months follow up (Keurbis & Sacco, 2013; Moore, Blow & Hoffing, 2010).

This evidence demonstrates that provision of relevant health information and brief interventions such as motivational interviewing are effective for older people with alcohol issues, in both mixed age and age-specific settings.
Population health issues

KEY MESSAGES: Population health

There is a lack of health promotion activity or resources targeted towards older people in relation to drugs and alcohol. Additionally, the messages to older people around safe use of alcohol are not clear or agreed, and there are no specific guidelines on safe/harmful drinking levels in Australia.

Sectors beyond the scope of this specific project may provide key opportunities for addressing the needs of older people with substance use issues, through direct service provision or through enhanced relationships and integration. These settings include primary health care settings, and aged care and aged health services. Aged care services in community and residential settings provide key support for older people with health and functional disabilities, and more work is needed to promote greater access to and service options/appropriate care for older people with drug and alcohol issues in those services, and stronger relationships between drug and alcohol (and mental health) services and aged care services for this group.

Although the scope of this project concerns improving the responses of NSW Health and NSW Health-funded drug and alcohol and mental health services, population health and health literacy issues have been highlighted through the project processes.

Consulted stakeholders repeatedly highlighted the need for broader health promotion in the community targeted at older people, and work in the primary care sector to address the target population’s needs, particularly those related to recognition of substance misuse issues. Some of the issues raised included the need for:

- Building the awareness and skills of GPs in recognising and treating substance misuse in older people. It was also noted that people may have been seeing their GP for substance use issues (possibly due to stigma, or their level of use being in the ‘risky’ level) and as they emerge from middle age and previous generally good health, comorbidities arise and the complexity increases leading to increased burden of care on the primary care service provider.
- A focus on early intervention.
- Raising awareness among older people in the community and rebadging the existing health promotion messages to encourage older people to see their primary care service providers.
- Providing health promotion activities/resources and ensuring they are in useful places such as TVS in GP waiting rooms, men’s sheds, libraries, and on the internet; reflecting the diverse cohorts in the 50+ age range.
- Education of older people around medication use and misuse, interaction of alcohol and medications, and complementary medications. Community pharmacists were identified by the Pharmacy Guild as a potential option for providing education and brief interventions.

Consultation participants highlighted that there is a lack of health promotion activity or resources targeted towards older people in relation to drug and alcohol. Additionally, the messages to older people around safe use of alcohol are not clear or agreed, and whilst the National Health and Medical Research Council Australian Guidelines to Reduce Health Risks from Drinking Alcohol do cover issues specific to age groups, there are no specific guidelines on safe/harmful drinking levels in Australia. Recent developments in the area include a series of fact sheets produced by NCETA: the ‘Grey Matters’ factsheets (links included at Appendix C: Useful resources and links) which are a positive development and will be built on in the work following this project.

It has been identified that sectors beyond the scope of this specific project may provide key opportunities for addressing the needs of older people with substance use issues, through direct service provision or through enhanced relationships and integration. These settings include primary health care settings, and aged care and aged health services. Aged care services in community and residential settings provide key support for older
people with health and functional disabilities, and more work is needed to promote greater access to and service options/appropriate care for older people with substance use issues in those services, and stronger relationships between drug and alcohol (and mental health) services and aged care services for this group.

**Aged care interface and accommodation issues**

**KEY MESSAGES: Aged care and accommodation issues**

There is a need for appropriate supported accommodation and support options for older people with drug and alcohol issues, including residential aged care. This need extends across the range of support needs, including permanent, appropriate supported accommodation.

Drug and alcohol and mental health services will need to consider key relationships and collaborative service delivery models with aged care and aged health services, as well as with further relevant health services including primary care and chronic care services. Collaboration will be required at a service delivery level, and also at a statewide planning and development level.

Whilst not the focus of this project, the need for appropriate supported accommodation and support options for older people with substance use issues, including residential aged care, was raised as a significant issue. Stakeholders identified there is a need for a variety of accommodation options to be available for the target population across the range of support needs, including permanent, appropriate supported accommodation. The need for support to be available for older people to maintain their accommodation was also reported, in the context of functional support services, and in relation to some forms of accommodation being at risk when people participate in residential rehabilitation. A NSW study found a high proportion of older drug and alcohol service users participating in the study identified as experiencing difficulty with activities of daily living (at much younger ages than comparable studies of people accessing geriatric services) (Lintzeris et al, 2015). Few of these people received services assisting with daily living, more than half reported a fall within the past 12 months, and the majority were socially isolated (Lintzeris et al, 2015).

Stakeholders consulted in project processes identified that community aged care services may have roles to play in harm minimisation, in supporting activities of daily living, and in preventing early admission to residential aged care facilities. Increased integration is a key theme of this project and recommendations. This includes all relevant services, noting that community aged care services may be a key partner.

It has also been identified that there are particular issues in accessing aged care services by the ‘younger old’ cohort. These people may be aged between 50 and 65 and experience premature ageing issues such as cognitive impairment, a multitude of physical health comorbidities, and reduced ability to independently manage activities of daily living, with a subsequent need for community or residential aged care. Whilst there is no lower age cut-off in the Aged Care Act, in practice it can be difficult for people to access these services under the age of 65 or 70.

Three examples of residential aged care facilities catering to the needs of particular subgroups within the broad scope of older people with substance use issues include Charles Chambers Court, Annie Green Court and Frederic House.

Charles Chambers Court is an inner Sydney Mission Australia residential aged care facility that particularly targets older people who are homeless or at risk of homelessness, many of whom have mental health and/or drug and alcohol issues. This facility was highlighted by stakeholders due to its ability to accept referrals for members of the project target population that might not be accepted by more generalist residential aged care facilities, and those individuals finding it an acceptable accommodation option. Annie Green Court is an inner Sydney residential aged care facility operated by Mission Australia, with a similar target group.

Frederic House is a St Vincent de Paul residential aged care facility in Sydney that caters to the needs of older men with mental health and/or drug and alcohol issues, by utilising a harm minimisation approach and provision of physical and mental health specialist supports.

Further to these inner-city options, there is a new residential aged care facility being planned in Orange, NSW, targeting older people who are homeless or at risk of homelessness, which may well also be a suitable option in the future for older people with histories of substance misuse.
In addition to the accommodation needs of the target population, there are significant service interfaces and partnerships relevant to project work and recommendations. Drug and alcohol and mental health services will need to consider key relationships and collaborative service delivery models with aged care and aged health services, as well as with further relevant health services including primary care and chronic care services. Collaboration will be required at a service delivery level, and also at a statewide planning and development level.

**Research gaps**

**KEY MESSAGES: Research gaps**

There are many gaps in our current knowledge regarding the extent of substance use issues in older people and effective management. Future research would be beneficial on prevalence and trends, and developing an evidence base on appropriate assessment and effective treatments, as well as understanding barriers and enablers.

There are many gaps in our current knowledge regarding the extent of substance use issues in older people and effective management. Future research would be beneficial on prevalence and trends, and developing an evidence base on appropriate assessment and effective treatments, as well as understanding barriers and enablers. Particular areas identified as gaps in current knowledge include:

- Epidemiological research re the quantum of the problem and trends in the extent, nature and predictors of substance use problems in older people. This would also relate to a better understanding of the many stratifications within the broad definition of older people, and of the subgroups in the identified cohorts.
- Standardised age-appropriate assessment and outcome measures that encourage comparability.
- Effective interventions for adults should be evaluated for suitability for older people.

- Development and evaluation of innovative treatments for older people, particularly:
  - Service models with a focus on long term outcomes
  - Service models incorporating higher treatment doses/compliance strategies
  - Service models and treatment approaches that address the needs of older cognitively impaired people with substance misuse issues.
- Considering how the harm reduction framework should be reframed for older people, including the development of age-specific drinking guidelines.
- Establishing the appropriate messages that resonate with older people through consultative processes.
- The intersection of age, culture and substance use.

Strategies suggested by stakeholders to address these knowledge gaps include promoting the inclusion of substance use and its varying effects into the current and proposed large scale studies of ageing in NSW, such as the ‘40 and up study’, and the Healthy Brain Ageing Program at the Brain and Mind Research Institute.
SECTION FIVE

Summary and Recommendations

In summary, this report has described the project’s target population and project purpose, and has highlighted some key themes relevant to older people and substance misuse. It has also described existing services available in NSW, noting factors that can act as barriers to service access for older people, as well as highlighting enablers, age-appropriate service design and elements, and positive practice examples.

Generally speaking, older people have the lowest rates of alcohol misuse, illicit drug use and tobacco consumption but the highest rates of prescription drug misuse. Any prevalence rates need to be treated with caution due to the widespread under-recognition of drug and alcohol issues among older people. In addition, there are generational changes expected as the ‘baby boomers’ arrive in the target age range, with early indications and predictions demonstrating this generation not only has been exposed to more and different patterns of substance use throughout their lives, but are also taking their habits through into later life.

There are numerous barriers to service access for older people with substance use issues, with under-recognition a continuing theme throughout. Stigma is another significant issue, and for those older people who have been identified as needing referral to drug and alcohol services, physical access and mixed age treatment settings can often act as barriers to access.

There is a paucity of research evidence nationally and internationally on specific best practice approaches and service models for older people with drug and alcohol issues. There is, however, a growing awareness of the need to develop improved responses, and professional opinion reports from respected sources are growing, such as that from the UK Royal College of Psychiatrists (2011).

The available evidence and expert opinion indicates that older people can respond equivalently to younger cohorts to mixed aged treatments, and that more treatment through length of stay or treatment adherence results in better outcomes for older people. Age-specific treatments can improve outcomes and service acceptability for older clients, and can involve: tailoring information to the age group (such as education about unique medical vulnerabilities to alcohol and combining medications); physical adaptations to treatment such as an accessible location or a slower pace of treatment, and/or psychosocial adaptions to treatment such as group therapy with topics relevant to life stage (e.g. coping with loss, grief, loneliness and life transitions).

As described throughout this report, older people with substance misuse problems are a diverse group with diverse needs. A range of recommendations are therefore indicated for NSW Health drug and alcohol and mental health services, from age-appropriate treatment and support of extended duration for those who are drug and/or alcohol dependent, to brief interventions for those whose substance use places their health at risk (DrugScope, 2014). In addition to these recommendations for NSW Health drug and alcohol and mental health staff and services, the literature review, consultations and analysis conducted for the project supports some broader recommendations pertaining to: support for those with issues with prescription and/or over-the-counter medications and the staff involved in their provision and monitoring; appropriate accommodation options for people across a spectrum of needs; and population health strategies.

Before proceeding to recommendations, it is worthwhile highlighting again that a range of outcomes may be appropriate and desirable for older people with drug and/or alcohol problems, in the context of person centred, holistic assessment and care. These outcomes might involve abstinence for some older people with substance use disorders, as well as a wide range of other outcomes focused on harm minimisation, improved health, and increased levels of wellbeing and social connectedness (DrugScope, 2014). Additionally, whilst recommendations for the aged care and aged health sectors are out of scope for this project, the report highlights some key issues and is intended to inform and encourage further work in this area.
Recommendations are broken down into: recommendations relating to MHDAO, NSW Ministry of Health (in collaboration with other parts of the Ministry and through advice to other relevant policy makers and services), recommendations for NSW drug and alcohol services, recommendations for NSW mental health services, and additional recommendations regarding priorities for further research. The following section outlines the recommendations in a brief format, with a more detailed version that includes examples or strategies and supporting information included at Appendix A: Annotated Project Recommendations.

Recommendations for MHDAO

1. **MHDAO should support a focus on addressing substance use in older people in policy, planning and service delivery in a range of sectors across NSW and nationally.**

   Key implementation strategies or markers will include:
   - Disseminating this report and associated documents widely, and communicating key findings through a range of forums and mechanisms.
   - Using this report to highlight key areas for further investigation and policy/service development regarding older people with substance use issues that were beyond the scope of the project (including aged health and hospital service responses, community and residential aged care service options, service options for older people with substance use disorders and cognitive impairment requiring supported care – particularly those under 65 years – and strategies around pharmaceutical misuse in older people).
   - Ensuring that statewide efforts to enhance service user/consumer consultation and engagement across the drug and alcohol and mental health programs include a focus on older people with drug and alcohol issues.
   - Using the findings and recommendations of this report to ensure the needs of older people with substance use issues, including prescription drug misuse, are appropriately addressed within:
     - NSW drug and alcohol and mental health planning models;
     - All relevant NSW Guidelines due for review, such as the *NSW Health Drug & Alcohol Psychosocial Interventions – Professional Practice Guidelines* and the *Drug and Alcohol Withdrawal Clinical Practice Guidelines – NSW*, and the *NSW Opioid Treatment Program: Clinical guidelines for methadone and buprenorphine treatment of opioid dependence*; as well as in the development of new policies and guidelines, and
     - Quality/service improvement initiatives in drug and alcohol services and mental health services across NSW.
   - Using this report and experts who contributed to its development to advise further regarding:
     - Drug and alcohol, cognitive and other screening tools appropriate for older people with substance use issues;
     - Assessment tools for inclusion in the drug and alcohol outcome measurement suite that are appropriate for older people;
     - Outcome measures appropriate for older people with substance use issues, and
     - Measures to address prescription drug misuse issues for older people.

2. **MHDAO should use the findings and recommendations of this report to inform statewide workforce and practice development initiatives in drug and alcohol and mental health services across NSW.**

3. **MHDAO should provide advice to the Centre for Population Health to support health promotion activity focused on older people and substance misuse.**

   Key implementation strategies or markers will include:
   - The development of consensus information on safe drinking limits specifically for older adults.
   - The development of factsheets for the public and healthcare professionals regarding alcohol use and older people, highlighting the balance of benefits and risks with alcohol use and appropriate strategies to address social isolation as a risk factor for alcohol misuse (e.g. social activities and events).
   - Work with the primary healthcare sector to increase awareness of the need to engage in regular alcohol screening, the screening tools that are available and appropriate referrals to services, supported by factsheets and information materials.
   - The development of factsheets for the public and healthcare professionals regarding prescription drug misuse issues for older people.
   - Addressing smoking by older people in mental health and drug and alcohol services in the context of addressing smoking in NSW Health facilities and services, as well as within broader NSW population health and tobacco strategies.
   - MHDAO promoting the Get Healthy Information and Coaching Service, which includes an alcohol consumption module, through relevant drug and alcohol and mental health services.
Recommendations for NSW drug and alcohol services

4. When planning and delivering services within existing mixed age settings, drug and alcohol services (including NGOs) should further develop their capacity to provide accessible and appropriate services for older people.

Key features of accessible and appropriate service responses include:

- The development of collaborative models with aged health services, older people’s mental health services and primary care services.
- Addressing the barriers for older people in accessing mixed age services (e.g. provision of outreach services and home visiting for appointments).
- Using the DACL service as a key point of referral for older people with substance use issues in the inpatient system. There are also significant opportunities across the hospital system for improving recognition and screening of drug and alcohol issues in older people, including prescription drug misuse; brief interventions; and referral to specialist drug and alcohol services.
- Management of coexisting physical conditions and psychological conditions being incorporated into treatment.
- Withdrawal identification and management practices being implemented in line with the considerations related to older people set out in NSW Drug and Alcohol Withdrawal Clinical Practice Guidelines (2008).
- Education of drug and alcohol staff on ageing-related issues.
- Key partnerships and relationships being developed and maintained, relevant to the local service context, to engage older Aboriginal people.
- Key partnerships and relationships being developed and maintained, relevant to the local demographics and service context, to engage older people from CALD backgrounds. These may include migrant and refugee services.
- Key partnerships and relationships being developed and maintained, relevant to the local demographics and service context, to engage older people experiencing homelessness.
- The engagement of families and carers in drug and alcohol service provision.
- Drug and alcohol services and staff having a well-developed understanding of the other relevant services available locally and statewide, their target populations and referral arrangements.
- Specialist drug and alcohol services supporting interventions by non-specialist workers in the general health, mental health, and aged care sectors.
- Addressing the under-recognition of tobacco use by older people. One component of this response will include implementing the Smoke-free Healthcare Policy within their services.

5. Drug and alcohol services should consider providing targeted services for older people.

Examples of strategies to achieve this recommendation include clinics established in primary care settings, ‘one stop shops’, structured screening pathways and shared care arrangements supported by cross sectoral relationships and support, and targeted prevention and treatment activities (see Appendix A: Annotated Project Recommendations for further details).

6. Drug and alcohol services should develop their capacity to provide appropriate screening and assessment processes for older service users.

Key features of appropriate processes will include:

- Understanding that applying the standard diagnostic criteria may not always be appropriate for older people.
- Understanding that safe drinking limits for older people have not been established in Australia, and will vary from client to client.
- Understanding that prescription drug misuse is a significant and growing issue among older people, and considering this in assessment and screening processes.
- All older service users being screened for cognitive impairment. Local consistency regarding tool use is important, although some recommended screens include:
  - The Arbias Acquired Brain Injury Screen (in CHOC)
  - The Montreal Cognitive Assessment (MoCA)
  - The Rowland Universal Dementia Assessment Scale (RUDAS)
- All older service users having physical health examinations as an important part of care, with clear systems and pathways for care coordination and referral in place.
- All older service users being asked their smoking status, with those who smoke being provided with brief intervention or more extensive smoking cessation support where required.
- All older service users being screened for mental health problems, particularly depression, with referral to treatment as appropriate.
7. Drug and alcohol services should develop their capacity to provide treatment interventions for older service users in a way that aligns with current consensus on good practice.

Key features include:

- Treatment of co-existing physical conditions and psychological conditions
- Age-specific therapy groups or age-specific therapy times
- Age-specific withdrawal management or detoxification support
- Age-specific treatment approaches such as tailoring information to the age of the service user, utilising a slower pace of treatment, and/or psychosocial adaptations to treatment such as group therapy with topics relevant to life stage
- Carer identification and engagement strategies being implemented in the treatment process
- Strategies to address cognitive impairment being utilised
- Drug and alcohol services linking their older clients into meaningful community engagement activities
- Harm reduction strategies being utilised in accordance with person centred goal setting and service provision
- The use of psychosocial treatment interventions to address losses, and regular suicide risk assessment, as per NSW Health Drug and Alcohol Psychosocial Interventions Professional Practice Guidelines (2008).

**Recommendations for NSW mental health services**

8. When planning and delivering services, mental health services should incorporate responses for older people with a primary or comorbid drug and alcohol issue.

Key features of appropriate service responses include:

- The development of links/partnerships with drug and alcohol services for referral and joint management of consumers with serious substance misuse problems.
- Services recognising and negotiating the stigma experienced by older people who may not identify as having a substance misuse disorder.
- SMHSOP (and aged health services) providing expertise and support to drug and alcohol services in cognitive screening and assessment, and referral to appropriate aged care and community support services.
- Utilisation of the DACL service as a key point of referral for older people with substance use issues (and comorbid mental health issues) in the inpatient system.
- Withdrawal identification and management practices being implemented in line with the considerations related to older people set out in NSW Drug and Alcohol Withdrawal Clinical Practice Guidelines (2008).
- Addressing the under-recognition of tobacco use by older people. One component of this response will include implementing the Smoke-free Healthcare Policy within their services.

- Mental health services developing workforce strategies such as:
  - Education and training of staff in order to be able to screen for and identify substance misuse issues, including the non-medical use of prescription and over the counter medication;
  - Education and training of staff in order to be able to provide brief interventions, and
  - Workforce support strategies where SMHSOP/adult mental health is the primary service supporting consumers with comorbidity or primary diagnosis of substance misuse.

9. Mental health services should provide routine screening and assessment of older service users with regards to substance use issues, including prescription drug misuse.

Key features include:

- Continued use of all screens in mandated Mental Health Outcomes and Assessment Tools (MH-OAT) systems, such as items in the triage and assessment modules, and the Mental Health Substance Use Assessment.
- Services understanding that applying the standard diagnostic criteria may not always be appropriate when screening older people for substance misuse, and that safe drinking limits for older people have not been established in Australia, and will vary from client to client.
- The use of recommended screening tools for alcohol and other substances:
  - For routine screening for alcohol use disorders, a recommended screen is the AUDIT-C (Bush et al, 1998)
  - A recommended screen incorporating substances besides alcohol is the ASSIST (see http://www.who.int/substance_abuse/activities/assist/en/)
  - The Indigenous Risk Impact Screen (IRIS) has been developed and validated for use with
Aboriginal people, for screening for alcohol and other substance misuse (as well as mental health problems). It has not been validated for older Aboriginal populations but can be a more culturally appropriate option to consider using initially.

- Services conducting a screen for cognitive impairment if there is a positive screen for substance misuse/alcohol misuse.
- A positive screen for alcohol and/or substance misuse resulting in either the provision of brief interventions, or referral to specialised drug and alcohol treatment according to the level of risk or dependence indicated in the screen outcome.
- All older service users being asked their smoking status, with those who smoke being provided with brief intervention or more extensive smoking cessation support where required.

10. Mental health services should develop some capacity to provide clinical care and interventions for older service users with substance use issues.

Key features of appropriate clinical care and interventions should include:

- Close collaboration and joint working with drug and alcohol services
- Provision of brief interventions by mental health staff, if they have engaged in appropriate education and training
- Mental health staff delivering brief interventions and ‘low risk drinking’ advice when working with older adults who are not dependent, but are drinking at risky or hazardous levels
- The provision of interventions relevant to addressing cognitive impairment in the delivery of clinical care
- The provision of interventions relevant to addressing social isolation, which may play an important part of addressing an older person’s substance misuse
- The provision of interventions relevant to harm reduction, in accordance with person centred goal setting and service provision.

Recommendations for research funding bodies and organisations

11. Future research should be conducted in the area, in light of the many gaps in our current knowledge regarding the extent of substance use issues in older people and effective management.

Key areas for further research include:

- Epidemiological understanding of prevalence and trends: Epidemiological research regarding the quantum of the problem and trends in the extent, nature and predictors of substance use problems in older people; and the intersection of age, culture and substance use.
- Developing an evidence base on appropriate assessment and effective treatments for older people with substance misuse issues, including prescription drug misuse: standardised age-appropriate assessment and outcome measures that encourage comparability; and effective interventions for adults should be evaluated for suitability for older people.
- Understanding barriers and enablers.
- Development and evaluation of innovative treatments for older people, particularly:
  - Service models with a focus on long term outcomes;
  - Service models and treatment approaches that address the needs of older cognitively impaired people with substance misuse issues, and
  - Service models incorporating higher treatment doses/compliance strategies.


Australian Commission on Safety and Quality in Health Care (ACSQHC) (2009). Preventing Falls and Harm From Falls in Older People: Best Practice Guidelines for Australian Hospitals, Community Care and Residential Aged Care Facilities


Draper, B. (2013). Final Research report to MHDAO: How common is substance use and abuse in clients presenting to Aged Care? (unpublished)


Network of Alcohol and Drug Agencies (NADA), 2013, Complex Needs Capable: A Practice Resource for Drug & Alcohol Services, Sydney Australia, NADA.


Recommendations are broken down into: recommendations relating to the Mental Health and Drug and Alcohol Office (MHDAO), NSW Ministry of Health (in collaboration with other parts of the Ministry and through advice to other relevant policy makers and services), recommendations for NSW drug and alcohol services, recommendations for NSW mental health services, and additional recommendations regarding priorities for further research.

The following set of recommendations includes supporting rationale and examples, with the basic set of recommendations in bold.

**Recommendations for MHDAO**

1. **MHDAO should support a focus on addressing substance use in older people in policy, planning and service delivery in a range of sectors across NSW and nationally.**

   **Key implementation strategies or markers will include:**
   - Disseminating this report and associated documents widely, and communicating key findings through a range of forums and mechanisms. These may include mental health benchmarking forums, Drug and Alcohol Quality in Treatment Advisory Group, LHD quality improvement activities, ACI mental health, aged health and drug and alcohol clinical network activities.
   - Using this report to highlight key areas for further investigation and policy/service development regarding older people with substance use issues that were beyond the scope of the project (including aged health and hospital service responses, community and residential aged care service options, service options for older people with substance use disorders and cognitive impairment requiring supported care – particularly those under 65 years – and strategies around pharmaceutical misuse in older people).
   - Ensuring that statewide efforts to enhance service user/consumer consultation and engagement across the drug and alcohol and mental health programs include a focus on older people with drug and alcohol issues, with particular attention to developing appropriate messages to promote recognition and help-seeking by older people with substance use issues, and developing effective strategies for engaging older people in assessment and treatment.
   - Using the findings and recommendations of this report to ensure the needs of older people with substance use issues, including prescription drug misuse, are appropriately addressed within:
     - NSW drug and alcohol and mental health planning models, such as development of the Drug & Alcohol Clinical Care and Prevention (DAC-CP) planning model, and used for drug and alcohol service planning in NSW, to ensure under-recognised and emerging needs of older people for drug and alcohol services and programs are addressed in service planning and resource allocation.
     - All relevant NSW Guidelines due for review, such as the NSW Health Drug & Alcohol Psychosocial Interventions – Professional Practice Guidelines and the Drug and Alcohol Withdrawal Clinical Practice Guidelines – NSW, and the NSW Opioid Treatment Program: Clinical guidelines for methadone and buprenorphine treatment of opioid dependence: as well as in the development of new policies and guidelines, and
     - Quality/service improvement initiatives in drug and alcohol services and mental health services across NSW, for example SMHSOP benchmarking and drug and alcohol quality improvement activities.
   - Using this report and experts who contributed to its development to advise further regarding:
     - Drug and alcohol, cognitive and other screening tools appropriate for older people with substance use issues;
     - Assessment tools for inclusion in the drug and alcohol outcome measurement suite that are appropriate for older people;
     - Outcome measures appropriate for older people with substance use issues, and
     - Measures to address prescription drug misuse issues for older people.

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**APPENDIX A**

**Annotated project recommendations**

Recommendations for MHDAO

1. **MHDAO should support a focus on addressing substance use in older people in policy, planning and service delivery in a range of sectors across NSW and nationally.**

   **Key implementation strategies or markers will include:**
   - Disseminating this report and associated documents widely, and communicating key findings through a range of forums and mechanisms. These may include mental health benchmarking forums, Drug and Alcohol Quality in Treatment Advisory Group, LHD quality improvement activities, ACI mental health, aged health and drug and alcohol clinical network activities.
   - Using this report to highlight key areas for further investigation and policy/service development regarding older people with substance use issues that were beyond the scope of the project (including aged health and hospital service responses, community and residential aged care service options, service options for older people with substance use disorders and cognitive impairment requiring supported care – particularly those under 65 years – and strategies around pharmaceutical misuse in older people).
   - Ensuring that statewide efforts to enhance service user/consumer consultation and engagement across the drug and alcohol and mental health programs include a focus on older people with drug and alcohol issues, with particular attention to developing appropriate messages to promote recognition and help-seeking by older people with substance use issues, and developing effective strategies for engaging older people in assessment and treatment.
2. MHDAO should use the findings and recommendations of this report to inform statewide workforce and practice development initiatives in drug and alcohol (e.g. education and training regarding particular needs of and issues faced by older people with substance use issues) and mental health services across NSW (e.g. training regarding drug and alcohol recognition and screening).

3. MHDAO should provide advice to the Centre for Population Health to support health promotion activity focused on older people and substance misuse.

Key implementation strategies or markers will include:

- The development of consensus information on safe drinking limits specifically for older adults, drawing on NH&MRC guidelines and highlighting the uncertainty of benefits and risks with alcohol use, surrounding life expectancy, cognitive impacts, and benefits and harm debate.
- The development of factsheets for the public and healthcare professionals regarding alcohol use and older people, highlighting the balance of benefits and risks with alcohol use and appropriate strategies to address social isolation as a risk factor for alcohol misuse (e.g. social activities and events). Translation of fact sheets should be considered, with appropriate consultation regarding language and content. Fact sheets will draw on existing resources including the NCETA Grey Matters information resources.
- Work with the primary healthcare sector to increase awareness of the need to engage in regular alcohol screening, the screening tools that are available and appropriate referrals to services, supported by factsheets and information materials.
- The development of factsheets for the public and healthcare professionals regarding prescription drug misuse issues for older people
- Addressing smoking by older people in mental health and drug and alcohol services in the context of addressing smoking in NSW Health facilities and services, as well as within broader NSW population health and tobacco strategies.
- Promoting the Get Healthy Information and Coaching Service, which includes an alcohol consumption module, through relevant drug and alcohol and mental health services.

Recommendations for NSW drug and alcohol services

Broadly, drug and alcohol services will need to consider strategies to improve their recognition of and engagement with older people with substance use issues in the context of mixed aged services, as well as consider some targeted service options for older people. Key components will include cognitive screening; collaboration with mental health services regarding assessment, treatment and support for mental health comorbidity (and cognitive impairment) and with aged health services regarding physical health and cognitive assessment; and aged and community care and support options.

4. When planning and delivering services within existing mixed age settings, drug and alcohol services (including NGOs) should further develop their capacity to provide accessible and appropriate services for older people.

Key features of accessible and appropriate service responses include:

- The development of collaborative models with aged health services, older people’s mental health services and primary care services. The development of links with mental health services may include initiatives and examples such as regular joint planning; collaborative meetings and training; and protocols being in place for referrals and transfer of clients, incorporating ‘warm referral’ strategies. Other key partners may include:
  - NGO mental health programs that may be providing or be appropriate to provide services for the older person
  - Hospital/general health services: DACL services; ASET workers; ACATs; chronic care workers; Aboriginal Health Workers, and discharge coordinators
  - Primary care: GPs; community pharmacists (particularly in relation in OTP and medication reviews).
- Addressing the barriers for older people in accessing mixed age services (e.g. provision of outreach services and home visiting for appointments). This will assist in preparing services to address the needs of older people with substance use issues as their numbers increase, and may involve:
- Addressing physical access issues experienced by those with impaired mobility or need to use mobility aids;
- Assistance with transport arrangements to centre-based services or provision of satellite or outreach services, which may involve satellite services operating out of community or primary care service settings;
- Adopting more collaborative and assertive ‘case management’ models or ‘complex care’ approaches to services;
- Removing unnecessary barriers in age-based eligibility criteria in care pathways;
- Addressing ‘therapeutic nihilism’ within drug and alcohol services in regards to older people with substances use issues, and
- Developing strategies to respond to the stigma experienced by older people who may not identify as having a substance misuse disorder.

Using the DACL service as a key point of referral for older people with substance use issues in the inpatient system. There are also significant opportunities across the hospital system for improving recognition and screening of drug and alcohol issues, including prescription drug misuse in older people, brief interventions and referral to specialist drug and alcohol services. Key potential referral partners include ASET workers, geriatric medical services and chronic care workers.

Management of coexisting physical conditions and psychological conditions being incorporated into treatment

Education of drug and alcohol staff on ageing-related issues

Key partnerships and relationships being developed and maintained, relevant to the local service context, to engage older Aboriginal people. Key partners may include Aboriginal Aged Care Workers in Aboriginal Medical Services (AMS); LHD Aboriginal Health Workers/Aboriginal Mental Health Workers; and local Aboriginal Community Controlled Health Services (ACCHS), including Aboriginal Aged Care services. Access and equity policy may involve formal partnerships, relationships with a range of Aboriginal health services and staff, culturally appropriate assessment, and addressing cultural competence in quality improvement plans.

Key partnerships and relationships being developed and maintained, relevant to the local demographics and service context, to engage older people from CALD backgrounds. Key partners may include local bilingual GPs; the Transcultural Mental Health Centre; NSW Service for the Treatment and Rehabilitation of Torture and Trauma Survivors (STARTTS); ethnospecific aged care organisations, and local CALD community groups and organisations. Access and equity policy may involve culturally appropriate assessment, acknowledging community and family as key partners in service planning and delivery, the budgeting for and use of interpreter services, and addressing cultural competence in quality improvement plans.

Key partnerships and relationships being developed and maintained, relevant to the local demographics and service context, to engage older people experiencing homelessness.

The engagement of families and carers in drug and alcohol service provision. This is important, yet complex with regards to disclosure and stigma. Some cohorts of older people are more likely than other consumers to have a carer involved; others may be isolated with minimal current relationships; whilst others may have a carer who themselves has a significant substance use problem or disorder. Families and carers of older people with substance use issues should be considered part of the broader target group of NSW drug and alcohol services.

Drug and alcohol services and staff having a well-developed understanding of the other relevant (aged health and mental health and wellbeing) services available locally and statewide, their target populations and referral arrangements in order to support collaborative care and appropriate referral. Key services will include those listed in the first bullet point in this recommendation.

Withdrawal identification and management practices being implemented in line with the considerations related to older people set out in NSW Drug and Alcohol Withdrawal Clinical Practice Guidelines (2008).

Specialist drug and alcohol services supporting interventions by non-specialist workers in the general health, mental health, and aged care sectors.

Addressing the under-recognition of tobacco use by older people. One component of this response will include implementing the Smoke-free Healthcare Policy within their services, which prohibits smoking on NSW Health grounds and facilities, with the exception of designated smoking areas which have been established under Local Health District by-laws.
5. Drug and alcohol services should consider providing targeted services for older people. Examples of strategies to achieve this recommendation include clinics established in primary care settings, ‘one stop shops’, structured screening pathways and shared care arrangements supported by cross sectoral relationships and support, and targeted prevention and treatment activities. Note these examples have not yet demonstrated outcomes based evidence as it is early in their development, but they are demonstrating positive experiences in a number of ways: collaboration on care pathways, engaged staff, and increased number of older people in the services.

- Clinics established or integrated into primary care settings have been found to increase engagement from older people and increase access to physical health care.
- One example of a collaborative and targeted approach is the ‘one stop shop’, which can improve accessibility to a large range of services for people with complex comorbidities or issues. Multiple care pathways can be organised more easily, bringing holistic and multidisciplinary care to the person in one appointment. This approach does not work for all cohorts of the target population but should be considered as part of a multifactorial approach.
- An example of a collaborative pathway is the cognitive assessment pathway pilot in South East Sydney LHD. All indicated patients are screened for cognitive impairment in the drug and alcohol service, and once screened, people are referred into old age psychiatry pathways if required. The physical location is a positive component; being co-located with existing services and being physically suitable for older people.
- The Older Wiser Lifestyle (OWL) service in Victoria has a preventative/early intervention component focussing on older people and alcohol misuse, and a treatment component encompassing other substances and medication misuse. The early intervention component centres around the target population completing the Australian Alcohol Related Problems Survey (A-ARPS) and strategies to facilitate this, such as staff members presenting at community organisations, older volunteers taking iPads loaded with the screen around hospitals, and the iPads being used at GP clinics in waiting rooms. Links to brief interventions and treatment are offered as indicated after screening. A key aspect of the treatment program component is that it consists of a more flexible and assertive service model, offering a slower pace as required, and home visits for appointments. One of the cognitive strategies used in the treatment component of the program is a DVD for consumers that summarises the advice and strategies provided.

6. Drug and alcohol services should develop their capacity to provide appropriate screening and assessment processes for older service users.

Key features of appropriate processes will include:

- Understanding that applying the standard diagnostic criteria may not always be appropriate for older people, particularly the functional criteria.
- Understanding that safe drinking limits for older people have not been established in Australia, and will vary from client to client according to a range of factors, meaning it is important not to over-interpret results.
- Some alcohol and drug use screens that have been trialled and/or evaluated for use with older people include:
  - ASSIST (Alcohol, Smoking and Substance Involvement Screening Test) (Humeniuk et al, 2010). Studies suggest using lower cut off point to improve sensitivity, although there is no consensus on a valid cut off point.
  - AUDIT (Alcohol Use Disorders Identification Test) and AUDIT-C (a three question screen, comprised of the consumption questions of the AUDIT) (Saunders et al 1993; Bush et al, 1998). Studies suggest using lower cut off points to improve sensitivity, although there is no consensus on a valid cut off point.
  - The Indigenous Risk Impact Screen (IRIS) has been developed and validated for use with Aboriginal people, for screening for alcohol and other substance misuse (as well as mental health problems). It has not been validated for older Aboriginal populations but can be a more culturally appropriate option to consider using initially.
- Understanding that prescription drug misuse is a significant and growing issue among older people, and considering this in assessment and screening processes.
- All older service users being screened for cognitive impairment, due to the high correlation between alcohol and/or substance use (regardless of age of onset) and cognitive impairment in older people. Below are some recommended cognitive screens, but it is important to note that there are a multitude of screens available, and local consistency between collaborating services is an important factor.
i. **The Arbias Acquired Brain Injury Screen built into CHOC** is reused with permission from arbias, and is a screening tool for acquired brain injury. One or more risk factors being identified should result in further specialised assessment.

ii. **The Montreal Cognitive Assessment (MoCA)** is a recommended cognitive screen that is currently used for IDAT patients and is promoted by NADA.

iii. **The Rowland Universal Dementia Assessment Scale (RUDAS)** is a short cognitive screening instrument designed to minimise the effects of cultural learning and language diversity on the assessment of baseline cognitive performance, and may be an appropriate choice for older people from CALD backgrounds.

- All older service users having physical health examinations as an important part of care, and referrals should be made as appropriate. The association of substance misuse (particularly alcohol) and physical conditions is high.
- All older service users being screened for mental health problems, particularly depression, with referral to treatment as appropriate. The association of substance misuse and mental health problems is significant, as is the under-recognition of depression in older people. Older clients should be screened for mental health problems, particularly depression, using existing tools, and ‘warm referral’ strategies used for referral as appropriate.
- All older service users being asked their smoking status, with those who smoke being provided with brief intervention or more extensive smoking cessation support where required.

7. **Drug and alcohol services should develop their capacity to provide treatment interventions for older service users in a way that aligns with current consensus on good practice.**

Key features include:

- Treatment of coexisting physical conditions and psychological conditions
- Age-specific therapy groups or age-specific therapy times to address general ageing, cognitive issues and social needs
- Age-specific withdrawal management or detoxification support
- Age-specific treatment approaches such as tailoring information to the age of the service user, utilising a slower pace of treatment, and/or psychosocial adoptions to treatment such as group therapy with topics relevant to life stage
- Carer identification and engagement strategies being implemented in the treatment process
- Strategies to address cognitive impairment being utilised. These may be recommended by collaborating aged health services, or may involve the drug and alcohol service employing a client-directed pace, supporting verbal communication with printed resources, carer engagement, and more assertive outreach strategies than traditionally used.
- Drug and alcohol services linking their older clients into meaningful community engagement activities to respond to underlying social isolation as a cause of substance misuse
- Harm reduction strategies being utilised in accordance with person centred goal setting and service provision. These may include thiamine injections; bone health screening and intervention such as vitamin D and calcium supplementation; liver health screening including fibroscan; and falls screening and risk mitigation.
- The use of psychosocial treatment interventions to address losses, and regular suicide risk assessment, as per **NSW Health Drug and Alcohol Psychosocial Interventions Professional Practice Guidelines (2008)**.

**Recommendations for NSW mental health services**

Broadly, mental health services should increase their awareness of the prevalence of drug and alcohol issues in older people and services and supports for this group, and be able to provide drug and alcohol screening, brief interventions for older people whose substance use is at risky levels, and referral to and collaborative care with drug and alcohol services for those with primary or serious comorbid substance use disorders.

8. **When planning and delivering services, mental health services should incorporate responses for older people with a primary or comorbid drug and alcohol issue.**

Key features of appropriate service responses include:

- The development of links/partnerships with drug and alcohol services for referral and joint management of consumers with serious substance misuse problems as primary diagnosis or comorbidity. Close liaison between all
professionals, disciplines and agencies involved in the care of the older person is of key importance.

- In seeking to engage with older people with substance use issues, services recognising and negotiating the stigma experienced by older people who may not identify as having a substance misuse disorder.
- Whilst there is a limited evidence base regarding how best to manage the cognitively impaired older adult with severe substance use disorders, SMHSOP (and aged health services) providing expertise and support to drug and alcohol services in cognitive screening and assessment, and referral to appropriate aged care and community support services.
- Utilisation of the DACL service as a key point of referral for older people with substance use issues (and comorbid mental health issues) in the inpatient system.
- Withdrawal identification and management practices being implemented in line with the considerations related to older people set out in NSW Drug and Alcohol Withdrawal Clinical Practice Guidelines (2008).
- Addressing the under-recognition of tobacco use by older people. One component of this response will include implementing the Smoke-free Healthcare Policy within their services, which prohibits smoking on NSW Health grounds and facilities, with the exception of designated smoking areas which have been established under Local Health District by-laws.
- Mental health services developing workforce strategies such as:
  - Education and training of staff in order to be able to screen for and identify substance misuse issues, including the non-medical use of prescription and over the counter medication
  - Education and training of staff in order to be able to provide brief interventions
  - Workforce support strategies where SMHSOP/adult mental health is the primary service supporting consumers with comorbidity or primary diagnosis of substance misuse. This may include a combination of education and training in assessment and brief intervention, and engagement with drug and alcohol services for support.

9. Mental health services should provide routine screening and assessment of older service users with regards to substance use issues, including prescription drug misuse.

Key features include:

- Continued use of all screens in mandated Mental Health Outcomes and Assessment Tools (MH-OAT) systems, such as items in the triage and assessment modules, and the Mental Health Substance Use Assessment. It is important to note however, that none of the alcohol/substance screening tools are designed for use with older people, and that applying the standard diagnostic criteria may not always be appropriate for older people, particularly the functional criteria.
- Services understanding that applying the standard diagnostic criteria may not always be appropriate when screening older people for substance misuse, and that safe drinking limits for older people have not been established in Australia, and will vary from client to client. It is important not to over-interpret results for this reason.
- The use of recommended screening tools for alcohol and other substances:
  - For routine screening for alcohol use disorders, a recommended screen is the AUDIT-C (Bush et al, 1998), a 3 item alcohol screen, which is a modified version of the 10 item Alcohol Use Disorders Identification Test (Saunders et al, 1993)
  - A recommended screen incorporating substances besides alcohol is the ASSIST (Alcohol, Smoking and Substance Involvement Screening Test). See http://www.who.int/substance_abuse/activities/assist/en/
  - The Indigenous Risk Impact Screen (IRIS) has been developed and validated for use with Aboriginal people, for screening for alcohol and other substance misuse (as well as mental health problems). It has not been validated for older Aboriginal populations but can be a more culturally appropriate option to consider using initially.
- Services conducting a screen for cognitive impairment if there is a positive screen for substance misuse/alcohol misuse. This is due to the established high correlations of substance use with cognitive impairment in older people, and the ability of the SMHSOP team to provide expertise and advice on cognitive impairment and strategies for the drug and alcohol care partners.
- In addition to any mandated screens on MH-OAT, below are some recommended cognitive screens, but it is important to note that there are a multitude of screens available, and local consistency between collaborating services is an important factor.
- The Acquired Brain Injury Screen built into CHOC is reused with permission from Arbias, and is a screening tool for acquired brain injury. One or more risk factors being identified should result in further specialised assessment.
- The Montreal Cognitive Assessment (MoCA) is a recommended cognitive screen that is currently used for IDAT patients and is promoted by NADA.
- The Rowland Universal Dementia Assessment Scale (RUDAS) is a short cognitive screening instrument designed to minimise the effects of cultural learning and language diversity on the assessment of baseline cognitive performance, and may be an appropriate choice for older people from CALD backgrounds.

- A positive screen for alcohol and/or substance misuse resulting in either the provision of brief interventions, or referral to specialised drug and alcohol treatment according to the level of risk or dependence indicated in the screen outcome.
- All older service users being asked their smoking status, with those who smoke being provided with brief intervention, or more extensive smoking cessation support where required.

10. Mental health services should develop some capacity to provide clinical care and interventions for older service users with substance use issues.

Key features of appropriate clinical care and interventions should include:

- Close collaboration and joint working with drug and alcohol services
- Provision of brief interventions by mental health staff, if they have engaged in appropriate education and training. These can include brief advice, brief motivational interviewing and brief counselling interventions.
- Mental health staff delivering brief interventions and ‘low risk drinking’ advice when working with older adults who are not dependent, but are drinking at risky or hazardous levels.
- The provision of interventions relevant to addressing cognitive impairment in the delivery of clinical care. Options will include but not be limited to supporting information or education provided in multiple formats including clear printed information; carer engagement; more assertive, outreach oriented service delivery; service providers using a communication style that compensates for cognitive impairment; provision of thiamine and other vitamin supplements as required, and considering application for appointment of a Guardian where the person lacks capacity to consent and is at risk of harm.

- The provision of interventions relevant to addressing social isolation, which may play an important part of addressing an older person’s substance misuse. These may involve mental health staff working with the person to identify and link in with personally relevant local social, vocational or community activities, or referral to other services regarding social engagement goals.
- The provision of interventions relevant to harm reduction, in accordance with person centred goal setting and service provision. These may involve education of the consumer and carer about safer levels of alcohol or other drug consumption than current use; reducing alcohol consumption by switching to low alcohol options; and/or reducing benzodiazepines by gradual withdrawal regime.

Recommendations for research funding bodies and organisations

11. Future research should be conducted in the area, in light of the many gaps in our current knowledge regarding the extent of substance use issues in older people and effective management.

Key areas for further research include:

- Epidemiological understanding of prevalence and trends: Epidemiological research regarding the quantum of the problem and trends in the extent, nature and predictors of substance use problems in older people; and the intersection of age, culture and substance use.
- Developing an evidence base on appropriate assessment and effective treatments for older people with substance misuse issues, including prescription drug misuse: standardised age-appropriate assessment and outcome measures that encourage comparability, and effective interventions for adults should be evaluated for suitability for older people.
- Understanding barriers and enablers.
- Development and evaluation of innovative treatments for older people, particularly:
  - Service models with a focus on long term outcomes
  - Service models and treatment approaches that address the needs of older cognitively impaired people with substance misuse issues
  - Service models incorporating higher treatment doses/compliance strategies.
Description of drug and alcohol services

While currently few drug and alcohol services in NSW cater specifically for the needs of older people, funding is allocated to Local Health Districts (LHD) to provide treatment services that can be accessed by this cohort. Services provided by frontline drug and alcohol workers include:

- early and brief intervention;
- pharmacotherapy services;
- detoxification and withdrawal management services;
- rehabilitation and counselling services;
- counselling, case management and assertive outreach for drug and alcohol users seeking assistance;
- addiction medicine services;
- health promotion and community engagement, and
- consultation liaison services.

It should be noted that not all Local Health Districts and Health Networks will provide the above-mentioned services.

In addition to those direct services provided by LHDs, the NSW Government provides funding for non-government organisations and other agencies to also provide:

- residential rehabilitation services;
- education and prevention services;
- advice and information;
- mass media and campaigns, and
- encouraging pharmacists and GPs to engage with the pharmacotherapy program.

Prevention and health promotion

Government plays a leading role in the development of preventative health campaigns related to drug and alcohol misuse. NSW Health undertakes a range of health promotion strategies, for example campaigns and resources, to promote healthy choices and provide information on risk and harms associated with alcohol and other drug use along with treatment and service options. Preventative approaches are very cost effective, long-lasting and have widespread community support.

Community Engagement and Action programs:
The main drug and alcohol preventative program in this area is the Community Engagement and Action program which supports Community Drug Action Teams (CDATs) across NSW. CDATs are coalitions of representatives from government agencies, non-government service providers, local businesses, welfare organisations and community members who identify and respond to drug and alcohol issues in their local communities. There are approximately 68 CDATs across NSW. Regionally based Project Officers deliver support to CDATs.

Community education campaigns: Media campaigns, including TV, radio, print and electronic media, provide information about the harms and risks related to drugs and alcohol. Such media campaigns provide education and support; encourage discussion; encourage engagement and reinforce positive individual and community behaviours; emphasise personal responsibility; explain drug addiction and encourage the use of treatment and rehabilitation services where needed.

Examples of campaigns include:

- What are you doing to yourself? which aims to reduce excessive and risky drinking amongst young people by promoting personal responsibility to alcohol consumption.
- Know When to Say When is a statewide campaign which aims at addressing excessive alcohol consumption for people over 25. The campaign challenges community attitudes to drinking by highlighting the negative consequences and impact of excessive alcohol consumption.
- The Cannabis Can Leave You Permanently out of It campaign aims to raise awareness with young adults about the harms associated with frequent and heavy cannabis use and encourages access to treatment options such as the Cannabis Clinics.
- The Get Healthy Information & Coaching Service is a free, confidential telephone-based service which helps people to make lifestyle changes regarding:
  - Healthy eating
  - Being physically active
  - Achieving and maintaining a healthy weight.

The Service was launched in February 2009 as part of New South Wales’ response to the Australian Better Health Initiative. Alcohol screening and advice is included in the service.
Early and Brief Intervention

What: Early interventions are appropriate services that are provided promptly after a problem is identified. This may follow systematic screening or the recognition of a problem by primary health providers. Brief intervention describes a wide variety of strategies that aim to change behaviour including brief advice, referral, brief motivational interviewing and brief counselling interventions and can be offered by generalist service providers if they have been prepared by appropriate education and training.

Brief interventions can be provided via telephone alcohol and drug information services. Support services for families and carers in order to help address the problematic drug and alcohol use within the NSW community are also available.

Where:
- Public drug and alcohol services and NGOs
- Primary care settings
- Confidential telephone support services are available through:
  - LHD Intake Lines
  - The Alcohol and Drug Information Service (ADIS): 24 hours a day, 7 days a week providing information, education, crisis counselling and referral service to the NSW population. The ADIS contact details for NSW are 02 9361 8000 (metro) and 1800 422 599 (rural).
- Family Drug Support service supports families in crisis due to drug and alcohol issues through a 24 hour a day, 7 days per week volunteer service.

Generalist Treatment and Extended Care Services

The NSW Government is responsible for ensuring that there is range of accessible drug and alcohol treatment services available in the community and that these services meet the range of biological, psychological and social needs of individuals. This includes establishing clear referral pathways to specialist services from hospitals and primary health services.

Local Health Districts deliver a range of drug and alcohol services along a continuum of care including: Intake Processing Assessment; Withdrawal Management (Detoxification); Addiction Medicine; Pharmacotherapy; Psychosocial Counselling; programs for specific substances; Inpatient Residential Rehabilitation; the Involuntary Treatment Program; Case Management and Assertive Outreach; Relapse Prevention and Aftercare Services.

The majority of state government funded drug and alcohol treatment is provided in generalist drug and alcohol services located in Local Health Districts, often aligned with major hospitals or other community health centres. A smaller proportion of people seeking treatment access residential rehabilitation programs, predominantly provided by NGOs.

Psychosocial support and counselling services

What: These outpatient services include a range of psychosocial interventions to assist people develop strategies to cease or reduce their substance use and to minimise risk of relapse.

Where: Many public drug and alcohol services located across NSW and within all LHDs provide outpatient psychosocial counselling and support services. These services may link in with other health services to address the range of needs of the population. In addition to a range of drug and alcohol services provided by all LHDs, NGOs deliver a large proportion of drug and alcohol treatment services in NSW. The Government provides funding to support over 1000 treatment places in a range of non-government service types. Treatment options in the non-government sector include community day programs; living skills programs; and a range of residential programs, including short-term programs, methadone to abstinence programs and long-term therapeutic communities.

Residential Rehabilitation

What: Residential rehabilitation is a term used to describe 24 hour, staffed, residential treatment programs that offer drug and alcohol interventions. Residential treatment is based on the principle that a structured drug/alcohol-free residential setting can provide an appropriate context to address the underlying causes of dependence.

Where: In NSW residential rehabilitation is predominantly provided by the NGO sector and private hospitals. NSW Health currently provides funds to 37 organisations to provide residential rehabilitation services.

Withdrawal Management Services

What: These services are designed to safely manage the withdrawal syndrome associated with cessation of drug use. The aim of withdrawal management is to ensure that withdrawal is completed safely and as comfortable as possible. This is often a necessary first step before further
treatment can commence. Managing withdrawal involves providing a combination of information, support, monitoring, and medication.

Where: All LHDs have some form of withdrawal management service. It can be undertaken in an inpatient, residential or ambulatory (community) setting. These services are generally short term and range between 3-14 days. These services can be provided in inpatient settings, either as a designated drug and alcohol unit attached to a hospital or in a general hospital ward. The services can also be delivered as part of a community based drug and alcohol service. Withdrawal management can also be provided by primary care practitioners. Inpatient withdrawal if often required when there is a high risk of acute withdrawal symptoms and where medication may be required (often used for alcohol and benzodiazepines).

Pharmacotherapy Services

What: The Opioid Treatment Program in NSW chiefly uses methadone and buprenorphine plus naloxone in its treatment of opioid dependence. These medications expand treatment options, have a high safety profile with a very low risk of overdose, reduced risk of diversion and are long acting with the ability to alleviate withdrawal symptoms. Research demonstrates that participation in an opioid treatment program results in major improvements in a patient’s social, personal and physical functioning. Other forms of pharmacotherapy treatment, such as for alcohol use, can be provided through public drug and alcohol clinics.

Where: All LHDs deliver some form of opioid treatment- either as a designated opioid treatment facility or through the community and via primary care and community pharmacies. The overall ‘Opioid Treatment Program’ comprises a mix of public clinics, private clinics, Justice Health & Forensic Health Network, community pharmacies and general practice.

Drug and Alcohol Consultation Liaison Services

What: Drug and Alcohol Consultation Liaison (DACL) services ensure that hospitals have timely access to specialist staff to assist in the management of patients presenting with mental health and drug and alcohol problems.

DACL services provide ED and general hospital staff with direct access to support with patient management and treatment advice. DACL has been found to reduce the costs that the burden of drug and alcohol use places on the health system by enhancing staff capacity to provide clinical care, manage substance use and refer patient to appropriate treatment.

Where: While most major NSW hospitals have some form of DACL services, some services operate with limited scope and others have been provided with designated CL funding. These funded services operate across 5 LHDs and one LHN.

Specialist Treatment

Specialist public drug and alcohol services and NGOs offer counselling, relapse prevention, and brief intervention. Specialist services targeting particular drugs of concern to assist in clients reducing their use and related harms; and specialist court diversion programs to reduce drug use and offending are largely provided by LHDs.

Stimulant Treatment Program

What: NSW Health has established two specialist treatment clinics for stimulant users. The clinics offer outpatient services to people 16 years and older seeking to stop or reduce their stimulant use. The aim of the program is to improve the health and social outcomes of people who use amphetamines through the provision of support services such as counselling, group work and relapse prevention. Pharmacotherapies (dexamphetamine) are provided to a small proportion of these clients. The services also link individuals in with a broad range of support including mental health.

Where: Two clinics operate in NSW. These are located at St Vincent’s Hospital, Darlinghurst, and in Newcastle, HNELHD. Both services accept people from outside of LHD/N.

Cannabis Clinics

What: Seven dedicated cannabis clinics have been set up to stand apart from the mainstream drug and alcohol treatment services and provide intensive clinical interventions and treatment to dependent cannabis users with complex needs, including clients with mental health issues.

Each of the clinics uses primarily a psychosocial approach to treatment.

Where: Provided by LHD’s – the seven clinics have been established at Parramatta, the Central Coast, Bathurst/Orange, Sutherland, Newcastle and the North Coast and Northern NSW.
Diversion Programs

What: The Diversion Program represents a partnership between NSW Health and Department of Justice. NSW Health is responsible for delivering programs to support people who have entered the criminal justice system address their substance abuse issues. These services include:

- Magistrates Early Referral into Treatment (MERIT): The MERIT Program is a 12 week community based drug and alcohol treatment program for those with a drug problem who present at one of 65 NSW Local Courts.
- Adult Drug Court Program: The Adult Drug Court of New South Wales is a specialised court based at Parramatta, Sydney (Downing Centre) and Toronto, Newcastle, which supervises the community-based rehabilitation of drug dependent offenders. The Adult Drug Court aims to reduce drug dependency, promote re-integration into the community and reduce drug-related crime.

Involuntary drug and alcohol treatment

What: Involuntary drug and alcohol treatment (IDAT) is a last resort treatment option to provide help and treatment to severely substance dependent persons who are at risk of serious harm, where all voluntary treatment options have been exhausted and the person no longer has the capacity to make decisions. The Drug and Alcohol Treatment Act (2007), the legislation that underpins the IDAT, allows for a person to be detained for inpatient treatment for up to 28 days, or up to three months if they have substance-related brain injury. The model of care includes a program of up to six months after the involuntary care phase by providing access to a range of treatments in both public and NGO sectors, depending on patient needs.

Where: IDAT is a statewide service based at two locations – Bloomfield Hospital in Orange, and the Herbert Street Clinic at Royal Sydney North Shore Hospital.

The Medically Supervised Injecting Centre (MSIC)

What: The Medically Supervised Injecting Centre provides a range of harm minimisation services including; assessment; a safe, clean, discreet environment for injecting drug users to inject under the supervision and care of qualified health professionals; immediate access to emergency medical care in the event of an overdose or adverse event; and professional staff who are able to engage with users and facilitate effective referral to a variety of services, including specialist addiction treatment.

Where: The MSIC is located in Kings Cross, Sydney.

Population specific

Aboriginal populations

What: Aboriginal residential rehabilitation services across NSW are being supported with funding provided to Aboriginal Community Controlled Health Services and specialist Aboriginal non-government organisations. Many LHDs have dedicated Aboriginal positions in liaison, casework and consultancy roles.

Where: Dedicated LHD Aboriginal positions are located within some LHD services and work across inpatient and community settings. The NSW Ministry of Health also contributes funding for an Addiction Medicine Staff Specialist in the Hunter New England Local Health District. The Network of Alcohol and Drug Agencies (NADA) includes over 30 member agencies that provide for Aboriginal clients and there are five Aboriginal Community Controlled Rehabilitation centres located in regional and rural NSW centres.

Culturally and Linguistically Diverse populations

What: The NSW Government provides funding to the Drug and Alcohol Multicultural Education Centre (DAMEC) to reduce the harm associated with the use of alcohol and other drugs within culturally and linguistically diverse (CALD) communities in New South Wales. DAMEC achieves these objectives through project work; provision of information to the sector and community; research and targeted programs include working with Vietnamese offenders to reduce recidivism and drug relapse; CALD parenting groups; outpatient counselling services for CALD communities; and working with CALD clients with co-morbid mental health drug and alcohol issues.

Where: DAMEC’s statewide activities are delivered from two sites at Redfern and Liverpool in NSW. These include a CALD Alcohol and Other Drugs counselling service based in Sydney South West and outreach to CALD communities in the Liverpool area.
Older people's mental health services

The key components of Specialised Mental Health Services for Older People (SMHSOP) are community teams, acute and non-acute inpatient services, and community residential care service models delivered in partnership with residential aged care providers in some areas.

The target population is generally people aged 65 years and over with a diagnosable mental health disorder or problem. However, SMHSOP also provide assessment and care for some ‘younger old’ people with complex comorbidity issues including mental illness, dementia, acquired cognitive impairment and/or substance use issues who have age-related problems causing significant functional disability. Access and referral arrangements are generally via the Mental Health Line (1800 011 511) or directly to the local mental health or SMHSOP service.

A summary table of the SMHSOP service elements follows.

Table 1: NSW Older People’s Mental Health Services

<table>
<thead>
<tr>
<th>Specialty Mental Health Services for Older People (SMHSOP) Community Teams</th>
<th>Where: Each Local Health District</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What:</strong></td>
<td>These teams have three major functions: specialist mental health assessment and treatment, care planning and case management for older people with severe and/or complex mental health problems. SMHSOP community teams provide consultation/liaison and conduct some capacity building with other key services, as well as delivering some activities with a prevention and early intervention focus. SMHSOP community teams may be involved in hospital admission and discharge processes, and work in partnership with other services such as aged health, aged care and GPs. Some SMHSOP community teams have specific staff or small teams that focus on assessment and management of older people with severe and complex behavioural and psychological symptoms of dementia, working closely with aged care services and other key services.</td>
</tr>
<tr>
<td><strong>SMHSOP Acute Inpatient Units</strong></td>
<td>Where: Various locations across NSW: Sydney, South West Sydney, North Sydney, Hunter New England, Southern, South Eastern Sydney, St Vincent’s, Western Sydney, Illawarra Shoalhaven, Central Coast LHDs</td>
</tr>
<tr>
<td><strong>What:</strong></td>
<td>SMHSOP acute inpatient services provide specialist psychiatric care for people who present with acute, severe symptoms of mental illness. Acute SMHSOP inpatient units may be discrete facilities or sub-units within acute mental health facilities or acute hospitals. The units provide multidisciplinary assessment of a person’s mental and behavioural status, including with physical health and psycho-social issues, and short term clinical treatment (voluntary or involuntary) for the acute phase of an illness which cannot be managed in the community.</td>
</tr>
<tr>
<td><strong>SMHSOP Non-Acute Inpatient Units (including Transitional Behavioural Assessment and Intervention Service – TBASIS – units)</strong></td>
<td>Non-acute SMHSOP inpatient units: Southern NSW, Western NSW, Northern Sydney, Hunter New England LHDs; SMHSOP sub-acute/non-acute inpatient unit in South Eastern Sydney LHD</td>
</tr>
<tr>
<td><strong>What:</strong></td>
<td>Non-acute mental health inpatient services have a primary focus on intervention to reduce functional impairments that limit the independence of the person and promote recovery. Non-acute mental health inpatient services provide specialist clinical assessment, treatment and rehabilitation where patients are not able to be managed in the community, with an expectation that consumers will improve sufficiently for discharge to a mainstream service or community setting with additional support from SMHSOP and other services. Strong links with residential and community services are important in these models.</td>
</tr>
<tr>
<td><strong>Transitional Behavioural Assessment and Intervention Service (TBASIS) Units</strong></td>
<td>Where: Western Sydney, Hunter New England, Southern NSW, Murrumbidgee LHDs</td>
</tr>
<tr>
<td><strong>Specialist interim care inpatient facilities provide multidisciplinary assessment, care planning and intensive treatment for older people with severe behavioural and psychological symptoms of dementia (BPSD).</strong></td>
<td><strong>Where:</strong></td>
</tr>
</tbody>
</table>
### SMHSOP Community Residential Care Service Models

**What:** Community residential care or extended care models provide long term care for people with severe and persistent psychiatric symptoms associated with dementia and or mental illness through partnerships between SMHSOP, aged care services/ACATS and the residential aged care sector. This includes the Mental Health Aged Care Partnership Initiative (MHACPI) model.

**Where:** Mental Health Aged Care Partnership Initiative (MHACPI) – 2 services: HammondCare (South Western Sydney LHD), and Catholic Health Care (Sydney LHD)

### Developing SMHSOP services

#### SMHSOP Consultation Liaison

**What:** Consultation liaison models provide specialist older people’s mental health advice and support for staff and teams in hospital settings who are primarily responsible for the care of the patient. Priority is given to people within geriatric wards, existing consumers of SMHSOP services or consumers within adult mental health services. Consultation liaison services can include assessment, referral and training with other service providers or teams. The core role of SMHSOP consultation liaison involves assisting in the management of patients known to the service and in supporting staff of adult mental health and geriatric medical wards in supporting older people with mental health disorders. In some areas, additional roles are also a component of consultation liaison. A lesser resourced consultation-liaison model would involve the consultation service providing advice regarding management of individual patients. In a more developed model, the liaison element is further established where there is joint development of capacity between the consultation/liaison team and identified services (such as geriatrics). Examples of joint capacity building work include the development of relevant protocols, joint case conferencing, or ‘Grand Rounds’. Consultation liaison services are provided by psychiatrist or old age psychiatrist and nursing staff.

**Where:** Predominately in metropolitan services – early stages of development.

#### Telepsychiatry

**What:** Telepsychiatry (access to a specialist mental health clinical input via telehealth) may be used as a supplement to face to face services, primarily providing assessment and case conference functions. Assessment may be undertaken by a psychiatrist or case conferencing by a senior clinician. Telepsychiatry may be used for specialist consultation in rural and remote areas, and for providing clinical support to clinicians working in these areas, often with a strong focus on capacity building. Telepsychiatry for SMHSOP can be effectively used in patient assessment and case conference as an adjunct to face-to-face psychiatry services, although recent service evaluations relevant to SMHSOP are limited. Examples within SMHSOP services include regular use of videoconferencing for clinical review of consumers, as well as clinical supervision and discussion of other clinical issues with staff and consumers in rural areas. Telepsychiatry services are provided by a psychiatrist or senior clinician with specialist older people’s mental health skills.

**Where:** Case conferencing and assessment (for adult) through MHEC-RAP in Western NSW LHD; Concord Hospital to Mid North Coast
Adult mental health services
The key components of adult mental health services are a combination of ambulatory services delivered usually by multidisciplinary community teams; acute, subacute and non-acute inpatient services; and community based services that aim to support quality of life, psychosocial functioning, integration accommodation and living needs, and carers.

The target group are adults 18-64 years, with serious mental illness or severe disorders with significant levels of disturbance or impairment. The target group may have complex needs, such as comorbidity, and includes those whose problems have not responded to primary care interventions, and people at risk to themselves or others. Access and referral arrangements are often initially through GPs, family members or friends, or directly by the local mental health service, or via the State Mental Health Telephone Access Line (1800 011 511).

A summary table of adult mental health service elements follows.

**Table 2: NSW Adult Mental Health Services**

<table>
<thead>
<tr>
<th>Adult Ambulatory and Community Clinical Mental Health Services</th>
<th>Where:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What:</strong> Adult ambulatory mental health services encompass three key service elements, which may be delivered by separate teams or staff. These are:</td>
<td>While all LHDs have ambulatory teams, the range of services provided by teams varies.</td>
</tr>
<tr>
<td>* Acute assessment and treatment services: Mobile Treatment Teams generally provide an extended hours service, providing triage and assessment and short term intensive treatment often in the form of home visits to patients to provide support and medication. These services work closely with hospital Emergency Departments, GPs and Generalist Community Health Teams assessing and screening patients to help avoid potential inpatient admissions where appropriate.</td>
<td>As LHD ambulatory team names do not necessarily reflect team function, LHDs should be contacted if more detail is sought on the availability of a particular type of ambulatory service.</td>
</tr>
<tr>
<td>* Continuing care services: Multidisciplinary teams (MDT) provide non-urgent assessment, treatment and case management. They have strong interfaces with primary care, for example providing advice and support to GPs, and provide shared care for consumers with chronic but stable conditions.</td>
<td></td>
</tr>
<tr>
<td>* Assertive community treatment services: These multidisciplinary teams provide extended hours, mobile, intensive mental health care to adults with severe mental illness who need a high level of clinical support, often due to comorbidity with intellectual disability, drug and alcohol issues or physical disability.</td>
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</table>

<table>
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<tr>
<th>Adult Ambulatory and Community Mental Health Services</th>
<th>Where:</th>
</tr>
</thead>
<tbody>
<tr>
<td>There are a range of further services delivered by NGOs complementing clinical mental health services.</td>
<td>HASI services are provided in all Local Health Districts, however, there are various types or levels of HASI. Not all HASI Services are available in all LHDs.</td>
</tr>
<tr>
<td>* Housing and Accommodation Support Initiative (HASI): These services are delivered by NGOs and are a core component of specialist mental health services complementing clinical mental health services, focusing on assisting people to live meaningful lives in the community. NGOs provide psychosocial support in partnership with the community mental health staff providing the clinical component of treatment, and social housing agencies provide permanent accommodation and landlord functions.</td>
<td>Other support and rehabilitation services are being delivered by NGOs in most LHDs. LHDs should be contacted if more detail is sought on the availability of NGO services in the region.</td>
</tr>
<tr>
<td>* Mental Health Support and Rehabilitation Services: NGOs deliver a range of other psychiatric disability rehabilitation and support services, such as supported accommodation; psychosocial rehabilitation day programs; mutual support and self-help; and the Family and Carer Mental Health Program.</td>
<td></td>
</tr>
</tbody>
</table>

----------------------------------------
1 Excluding forensic services
### Adult inpatient services

**What:**
Adult inpatient services encompass emergency care, acute, sub-acute and non-acute services, as follows:

- **Psychiatric Emergency Care Centre (PECC):** The PECC model provides 24 hour consultation to Emergency Department (ED), and also a small 4-6 bed mental health inpatient unit located within the EDs.
- **Adult acute inpatient services:** These services provide voluntary and involuntary short term hospital treatment during an acute phase of an illness.
- **Adult sub-acute inpatient services:** These services include a range of dependency levels and a range of sub-specialist beds for people who require medium stay clinical treatment. The units have MDT including peer workers, and clinical rehabilitation approach. They work in partnership with community NGOs to ensure successful transition back into the community.
- **Secure Non-acute Extended Care Inpatient Services:** These services provide medium to long term hospital care for people who have significant levels of disturbance and whose treatment and support needs cannot be met in a residential setting and require secure settings due to their level of risk. Generally provided on a statewide basis.

**Where:**
Each Local Health District provides adult inpatient services, however, availability of the range of services (PECCs, acute, subacute and non-acute) varies. Acute inpatient units are found in all LHDs, whilst PECCs are generally only available in larger metropolitan and a few larger regional hospitals and subacute and non-acute varies.

### Developing Services:

- **Specialist Living Support Services (non-acute):** These are newly developing services in the community that will be delivered by specialist NGOs to address the needs of a range of people with enduring and complex mental illness. Many of these people will have been long-stay inpatients and have not been able to be transitioned to the community due to the lack of appropriate care models. Accommodation is built specifically for different ranges of risk and disability levels and aims to be able to cater for people in higher needs phases of episodic illnesses.
- **HASI Plus (non-acute):** These services are delivered by NGOs and comprise 16 or 24 hour a day psychosocial supports for people with severe and persistent mental illness in collaboration with specialist clinical services. It provides stable accommodation with those services and assists people to live in the community after having been in institutional care for a long time.
APPENDIX C

Useful resources and links

**NCETA Fact Sheets – Grey Matters**
These fact sheets were released in 2014 by NCETA. There are seven fact sheets covering the context and background to the emerging issue of older people with substance use issues, generational changes, prevention and screening, barriers and enablers, common comorbidities, and opioids and pain. There is also an eighth sheet containing references and links.

Available from:

**NADA Complex Needs Capable Toolkit**
The Network of Alcohol and other Drugs Agencies (NADA) released the *Complex Needs Capable: A Practice Resource for Drug and Alcohol Services* in 2014. This is available online and contains information for drug and alcohol services related to clients with complex needs, including practical tips and information regarding cognitive impairment.

Available at:

**Alcohol and Drug Information Service (ADIS)**
The Alcohol and Drug Information Centres are state and territory-based services that offer information, advice, referral, intake, assessment and support 24 hours a day. They offer services for individuals, their family and friends, general practitioners, other health professionals and business and community groups.

The ADIS contact details for NSW are 02 9361 8000 (metro) and 1800 422 599 (rural).

**NPS MedicineWise fact sheets**
There is a range of information and resources available on the NPS MedicineWise website relevant to older people and medications. These can be found at http://www.nps.org.au/topics/ages-life-stages/for-individuals/older-people-and-medicines.

**ACI Pain management website**
The NSW Agency for Clinical Innovation (ACI) has produced a website containing useful information for individuals with chronic pain, and information and resources for health professionals on the assessment and management of pain. It has an emphasis on a balanced approach to pharmacological and non-pharmacological approaches to pain management.


**Australian Indigenous Alcohol and Other Drug Knowledge Centre**
This website includes information on the evidence base to reduce harmful AOD use in Aboriginal and Torres Strait Islander communities. It has portals for AOD workers and for communities.

http://www.aodknowledgecentre.net.au/
## Table 3: Older People’s Drug and Alcohol Project Expert Advisory Group

<table>
<thead>
<tr>
<th>Membership as per ToR</th>
<th>Representative</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Advisor, Older People’s Mental Health (OPMH) Policy Unit, MHDAO, NSW Ministry of Health</td>
<td>Dr John Dobrohotoff (co-chair) Clinical Advisor, Older People’s Mental Health (OPMH) Policy Unit, MHDAO Clinical Director, SMHSOP, Central Coast LHD</td>
</tr>
<tr>
<td>Academic/Expert representatives</td>
<td>Professor Brian Draper (co-chair) Conjoint Professor, School of Psychiatry, University of NSW (UNSW) Acting Director, Academic Department for Old Age Psychiatry Prince of Wales Hospital, South East Sydney (SES) Local Health District (LHD) Dr Apo Demirkol Conjoint Associate Professor, UNSW Staff Specialist, Drug and Alcohol Services, SES LHD</td>
</tr>
<tr>
<td>Clinical Director Drug and Alcohol LHD (rural and metro) – Quality in Treatment (QIT) Committee representatives</td>
<td>Dr Nghi Phung Director, Drug Health Western Sydney LHD/Staff Specialist Addiction Medicine Westmead Hospital / Staff Specialist Gastroenterology and Hepatology Westmead Hospital Ms Kristine Smith District Clinical Coordinator Drug and Alcohol Program, Western NSW LHD</td>
</tr>
<tr>
<td>LHD Drug and Alcohol Director</td>
<td>Ms Karen Becker Director, Drug and Alcohol Services Sydney/South Western Sydney LHD Replaced by Dr Paul Haber in 2015</td>
</tr>
<tr>
<td>Aged Care representative, NSW Ministry of Health</td>
<td>Ms Barbara Anderson Principal Policy Adviser – Ageing and Disability Aged Care Unit Integrated Care Branch, NSW Ministry of Health</td>
</tr>
<tr>
<td>Agency for Clinical Innovation (ACI) Aged Health representative</td>
<td>Dr David Burke Director Psychogeriatrics, St Vincent’s Hospital</td>
</tr>
<tr>
<td>Clinical Excellence Commission representative</td>
<td>Dr Peter Kennedy Deputy Chief Executive Officer Clinical Excellence Commission Correspondence only</td>
</tr>
<tr>
<td>Clinical Director Mental Health – LHD</td>
<td>Mr John Leary Director, Mental Health and Drug and Alcohol Services Mid North Coast LHD</td>
</tr>
<tr>
<td>Carer organisation</td>
<td>Ms Sue Gates Carer Engagement Officer Mental Health Carers ARAFMI NSW Replaced by Mr Richard Baldwin in 2015</td>
</tr>
<tr>
<td>Carer organisation</td>
<td>Mr Tony Trimingham Chief Executive Officer, Family Drug Support</td>
</tr>
<tr>
<td>Network of Alcohol and Other Drugs Agencies (NADA) representative</td>
<td>Mr Robert Stirling /Ms Heidi Becker Program Manager, NADA</td>
</tr>
<tr>
<td>Membership as per ToR</td>
<td>Representative</td>
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<tr>
<td>-----------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>CALD representative</td>
<td><strong>Ms Karen Redding</strong>&lt;br&gt;Senior Project Officer, Drug and Alcohol Multicultural Education Centre (DAMEC)</td>
</tr>
<tr>
<td>Aboriginal representative</td>
<td><strong>Ms Monique McEwan</strong>&lt;br&gt;Senior Aboriginal Drug and Alcohol Network (ADAN) Project Officer, Aboriginal Health and Medical Research Council NSW (AH&amp;MRC)</td>
</tr>
<tr>
<td>SMHSOP Advisory Group representative</td>
<td><strong>Mr Stephen Kay</strong>&lt;br&gt;Clinical Nurse Consultant, SMHSOP&lt;br&gt;Northern Sydney LHD</td>
</tr>
<tr>
<td>Manager, OPMH Policy Unit, and relevant team members</td>
<td><strong>Dr Kate Jackson</strong>&lt;br&gt;<strong>Ms Lindsay Penson</strong>&lt;br&gt;Older People's Mental Health Policy Unit, MHDAO, NSW Ministry of Health</td>
</tr>
<tr>
<td>Manager, Drug and Alcohol Clinical Standards and Design Team, and relevant team members</td>
<td><strong>Ms Debbie Kaplan</strong>&lt;br&gt;<strong>Ms Meredith Sims</strong>&lt;br&gt;Drug and Alcohol Clinical Standards and Design Team, MHDAO, NSW Ministry of Health</td>
</tr>
<tr>
<td>Drug and Alcohol Population and Community Programs, NSW Ministry of Health</td>
<td><strong>Mr Ralph Moore</strong>&lt;br&gt;Acting Director, Drug and Alcohol Population and Community Programs, Centre for Population Health, NSW Ministry of Health</td>
</tr>
<tr>
<td>Opioid Treatment Managers Network</td>
<td><strong>Ms Josephine Mencigar</strong>&lt;br&gt;Nursing Unit Manager, Fleet StOpioid Treatment Unit</td>
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<tr>
<td>Involuntary Drug and Alcohol Treatment (IDAT) Program representatives</td>
<td><strong>Mr Adrian Francis</strong>&lt;br&gt;Clinical Nurse Consultant&lt;br&gt;IDAT, Northern Sydney LHD</td>
</tr>
<tr>
<td>Geriatrician representative</td>
<td><strong>Dr Sunil Gupta</strong>&lt;br&gt;Clinical Director of the Division of Rehabilitation and Aged Care, Central Coast LHD</td>
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<td>National Drug and Alcohol Research Centre (NDARC) representative</td>
<td><strong>Dr Lucy Burns</strong>&lt;br&gt;<strong>Dr Wendy Swift</strong>&lt;br&gt;Senior Lecturers/Senior Research Fellows&lt;br&gt;NDARC, UNSW</td>
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APPENDIX E

Consultation Details

The following table outlines the roles and organisations of stakeholders consulted during project processes prior to the preparation and release of the draft project report. In addition to the following table, the project’s Expert Advisory Group consulted and advised at each project stage, and an early draft project report was provided to the ACI Aged Health Network co-chairs and representatives from the nursing and allied health subgroups, with feedback received and incorporated into the consultation draft report.

The stakeholders invited to comment on the pre-final, consultation draft Project Report follow this table.

**Table 4: Older People’s Drug and Alcohol Project – Consultation Details**

<table>
<thead>
<tr>
<th>Identified Stakeholder Group</th>
<th>Details</th>
<th>Nos</th>
<th>Locations/Method</th>
<th>Sub-totals</th>
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<td>Office of the Public Guardian (OPG)</td>
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<td>Locations/Method</td>
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<td>IDAT Social Worker</td>
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<td>TOTAL NUMBERS</td>
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Further consultation with key groups and organisations occurred via the consultation draft project report. Comment and feedback was incorporated into revised draft before endorsement by the EAG. Stakeholders invited to comment on the consultation draft included:

- **LHD and Specialty Network representatives:** The draft report was sent to Chief Executives, Directors of Drug and Alcohol and Mental Health, and SMHSOP Coordinators or equivalent.

- **Pillars and Ministry branches:** Agency for Clinical Innovation; Clinical Excellence Commission; NSW Ministry of Health Integrated Care Branch, Legal and Regulatory, for Pharmaceutical Services Unit, Workforce Planning & Development, Centre for Population Health, Centre for Aboriginal Health, Office of the Chief Health Officer, and InforMH.

- **NGOs and peak organisations:** NADA, AH&MRC, DAMEC, NSW Being, Family Drug Support, NSW Carers ARAFMI, NDARC, NUAA – NSW Users and AIDS Association, FPOA (Royal Australian and NZ College of Psychiatrists, Faculty of Psychiatry of Old Age), Royal Australasian College of Physicians (RACP) Australasian Chapter of Addiction Medicine, RANZCP Section of Addiction Psychiatry, Aged & Community Services NSW & ACT, and Leading Aged Services Australia, NSW-ACT.

- **The range of relevant committees:** Drug and Alcohol Program Council, Mental Health Program Council, MHDAO Clinical Advisory Council, MHDAO Quality in Treatment Committee, SMHSOP Advisory Group, Mental Health Consumer Sub-committee.
APPENDIX F

Data Definitions

Drug and alcohol service data

Data Source: Alcohol and Other Drugs Treatment Services (AODTS) data was extracted from Health Information Exchange Drug and Alcohol Database on 31 Oct 2014.

Notes:
- Inclusion: The data includes both own drug use and other’s drug use for Drug and Alcohol Client Type by period. Only includes own drug use for remaining data.
- Only includes closed treatment episodes data.
- Unable to define unique client in the Drug and Alcohol data as the unique identifier information is not available in the drug and alcohol data.
- Please be aware that some LHDs may not have drug and alcohol episode cases for all age groups.
- One episode care could have multiple ‘other drug of concern’ or no ‘other drug of concern’.
- One episode care could have multiple ‘other service provided’ or no ‘other service provided’.
- All figures rounded to nearest whole number.
- No Drug and Alcohol data collection is available at Justice Health.
- Drug and Alcohol data collection is incomplete in the earlier 4 year periods. Caution is required when interpreting the trends in Drug and Alcohol episode care data.

Table 5: Drug and alcohol codes and description

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<tr>
<td>2. Drug and Alcohol Database for Drug concern coding is based on Drug of concern, first edition 2000</td>
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<td>3. Below only kept the Drug of concern, first edition codes and description</td>
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### Drug and Alcohol Concern Codes and Description

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<td>Paracetamol</td>
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#### 2 SEDATIVES AND HYPNOTICS

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##### 22 Anaesthetics

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##### 25 GHB Type Drugs and Analogues

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#### 3 STIMULANTS AND HALLUCINOGENS

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<td>DOB</td>
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</tr>
<tr>
<td>3402</td>
<td>DOM</td>
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</tr>
<tr>
<td>3403</td>
<td>MDA</td>
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<td>3404</td>
<td>MDEA</td>
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<td>3405</td>
<td>MDMA</td>
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<td>3406</td>
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<tr>
<td>3407</td>
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<td>3408</td>
<td>TMA</td>
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</tr>
<tr>
<td>3499</td>
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<td>Other Stimulants Including Caffeine</td>
</tr>
<tr>
<td>35</td>
<td>Tryptamines</td>
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<td>3501</td>
<td>Atropinic alkaloids</td>
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</tr>
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<td>3502</td>
<td>Diethyltryptamine</td>
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<td>3503</td>
<td>Dimethyltryptamine</td>
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<td>Lysergic acid diethylamide</td>
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<td>Psilocybin</td>
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<td>Tryptamines, nec</td>
<td>Other Stimulants Including Caffeine</td>
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<td>36</td>
<td>Volatile Nitrates</td>
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<td>3601</td>
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<td>Butyl nitrate</td>
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<td>Volatile Nitrates, nec</td>
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<tr>
<td>39</td>
<td>Other Stimulants and Hallucinogens</td>
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<tr>
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<td>Caffeine</td>
<td>Other Stimulants Including Caffeine</td>
</tr>
<tr>
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<td>Cathinone</td>
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</tr>
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<td>Cocaine</td>
<td>Cocaine</td>
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<tr>
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<td>Methcathinone</td>
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<td>Methylphenidate</td>
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</tr>
<tr>
<td>3906</td>
<td>Nicotine</td>
<td>Nicotine</td>
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<tr>
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#### ANABOLIC AGENTS AND SELECTED HORMONES

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>41</td>
<td>Anabolic Androgenic Steroids</td>
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<tr>
<td>4101</td>
<td>Boldenone</td>
<td>Other</td>
</tr>
<tr>
<td>4102</td>
<td>Dehydroepiandrosterone</td>
<td>Other</td>
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<tr>
<td>4103</td>
<td>Fluoxymesterone</td>
<td>Other</td>
</tr>
<tr>
<td>4104</td>
<td>Mesterolone</td>
<td>Other</td>
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<td>4105</td>
<td>Methandroil</td>
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<tr>
<td>4106</td>
<td>Methenolone</td>
<td>Other</td>
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<td>4107</td>
<td>Nandrolone</td>
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<tr>
<td>4108</td>
<td>Oxandrolone</td>
<td>Other</td>
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<tr>
<td>4111</td>
<td>Stanozolol</td>
<td>Other</td>
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<tr>
<td>4112</td>
<td>Testosterone</td>
<td>Other</td>
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<tr>
<td>4199</td>
<td>Anabolic Androgenic Steroids, nec</td>
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### Drug and Alcohol concern codes and description

<table>
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<th>Code</th>
<th>Description</th>
<th>Type</th>
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<tr>
<td>42</td>
<td>Beta$_2$ Agonists</td>
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<tr>
<td>4201</td>
<td>Eformoterol</td>
<td>Other</td>
</tr>
<tr>
<td>4202</td>
<td>Fenoterol</td>
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<td>4203</td>
<td>Salbutamol</td>
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<td>4299</td>
<td>Beta$_2$ Agonists, nec</td>
<td>Other</td>
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<td>43</td>
<td>Peptide Hormones, Mimetics and Analogues</td>
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<tr>
<td>4301</td>
<td>Chorionic gonadotrophin</td>
<td>Other</td>
</tr>
<tr>
<td>4302</td>
<td>Corticotrophin</td>
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<tr>
<td>4303</td>
<td>Erythropoietin</td>
<td>Other</td>
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<td>4304</td>
<td>Growth hormone</td>
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<td>4305</td>
<td>Insulin</td>
<td>Other</td>
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<tr>
<td>4399</td>
<td>Peptide Hormones, Mimetics and Analogues, nec</td>
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<td>49</td>
<td>Other Anabolic Agents and Selected Hormones</td>
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<tr>
<td>4901</td>
<td>Sulfonylurea hypoglycaemic agents</td>
<td>Other</td>
</tr>
<tr>
<td>4902</td>
<td>Tamoxifen</td>
<td>Other</td>
</tr>
<tr>
<td>4903</td>
<td>Thyroxine</td>
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<tr>
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<td>Other Anabolic Agents and Selected Hormones, nec</td>
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### 5 ANTIDEPRESSANTS AND ANTIPSYCHOTICS

#### 51 Monoamine Oxidase Inhibitors

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<th>Code</th>
<th>Name</th>
<th>Type</th>
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<td>5101</td>
<td>Moclobemide</td>
<td>Other</td>
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<tr>
<td>5102</td>
<td>Phenelzine</td>
<td>Other</td>
</tr>
<tr>
<td>5103</td>
<td>Tranylcypromine</td>
<td>Other</td>
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<tr>
<td>5199</td>
<td>Monoamine Oxidase Inhibitors, nec</td>
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#### 52 Phenothiazines

<table>
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<th>Code</th>
<th>Name</th>
<th>Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>5201</td>
<td>Chlorpromazine</td>
<td>Other</td>
</tr>
<tr>
<td>5202</td>
<td>Fluphenazine</td>
<td>Other</td>
</tr>
<tr>
<td>5203</td>
<td>Pericyazine</td>
<td>Other</td>
</tr>
<tr>
<td>5204</td>
<td>Thioridazine</td>
<td>Other</td>
</tr>
<tr>
<td>5205</td>
<td>Trifluoperazin</td>
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<tr>
<td>5299</td>
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#### 53 Serotonin Reuptake Inhibitors

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<td>5301</td>
<td>Citalopram</td>
<td>Other</td>
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<tr>
<td>5302</td>
<td>Fluoxetine</td>
<td>Other</td>
</tr>
<tr>
<td>5303</td>
<td>Paroxetine</td>
<td>Other</td>
</tr>
<tr>
<td>5304</td>
<td>Sertraline</td>
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<tr>
<td>5399</td>
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#### 54 Thioxanthenes

<table>
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<th>Code</th>
<th>Name</th>
<th>Type</th>
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<tr>
<td>5401</td>
<td>Flupenthixol</td>
<td>Other</td>
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<tr>
<td>5402</td>
<td>Thiothixene</td>
<td>Other</td>
</tr>
<tr>
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</table>

#### 55 Tricyclic Antidepressants

<table>
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<th>Code</th>
<th>Name</th>
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</thead>
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<tr>
<td>5501</td>
<td>Amitriptyline</td>
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<tr>
<td>5502</td>
<td>Clomipramine</td>
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</tr>
<tr>
<td>5503</td>
<td>Dothiepin</td>
<td>Other</td>
</tr>
<tr>
<td>5504</td>
<td>Doxepin</td>
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</tr>
<tr>
<td>5505</td>
<td>Nortriptyline</td>
<td>Other</td>
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<tr>
<td>Drug and Alcohol concern codes and description</td>
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</tr>
<tr>
<td>-----------------------------------------------</td>
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<td></td>
</tr>
<tr>
<td>5599</td>
<td>Tricyclic Antidepressants, nec</td>
<td>Other</td>
</tr>
<tr>
<td>60</td>
<td>Other Antidepressants and Antipsychotics</td>
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<tr>
<td>5901</td>
<td>Butyrophenones</td>
<td>Other</td>
</tr>
<tr>
<td>5902</td>
<td>Lithium</td>
<td>Other</td>
</tr>
<tr>
<td>5903</td>
<td>Mianserin</td>
<td>Other</td>
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<tr>
<td>5999</td>
<td>Other Antidepressants and Antipsychotics, nec</td>
<td>Other</td>
</tr>
</tbody>
</table>

6 VOLATILE SOLVENTS

| 61  | Aliphatic Hydrocarbons |
|-----------------------------------------------|
| 6101  | Butane | Other |
| 6102  | Petroleum | Other |
| 6103  | Propane | Other |
| 6199  | Aliphatic Hydrocarbons, nec | Other |

| 62  | Aromatic Hydrocarbons |
|-----------------------------------------------|
| 6201  | Toluene | Other |
| 6202  | Xylene | Other |
| 6299  | Aromatic Hydrocarbons, nec | Other |

| 63  | Halogenated Hydrocarbons |
|-----------------------------------------------|
| 6301  | Bromochlorodifluoromethane | Other |
| 6302  | Chloroform | Other |
| 6303  | Tetrachloroethylene | Other |
| 6304  | Trichloroethylene | Other |
| 6305  | Trichloroethylene | Other |
| 6399  | Halogenated Hydrocarbons, nec | Other |

| 69  | Other Volatile Solvents |
|-----------------------------------------------|
| 6901  | Acetone | Other |
| 6902  | Ethyl acetate | Other |
| 6999  | Other Volatile Solvents, nec | Other |

9 MISCELLANEOUS DRUGS OF CONCERN

| 91  | Diuretics |
|-----------------------------------------------|
| 9101  | Antikaliuretics | Other |
| 9102  | Loop diuretics | Other |
| 9103  | Thiazides | Other |
| 9199  | Diuretics, nec | Other |

| 92  | Opioid Antagonists |
|-----------------------------------------------|
| 9201  | Naloxone | Other |
| 9202  | Naltrexone | Other |
| 9299  | Opioid Antagonists, nec | Other |

| 93  | Laxatives |
|-----------------------------------------------|
| 9301  | Laxatives | Other |

| 99  | Other Drugs of Concern |
|-----------------------------------------------|
| 9999  | Other Drugs of Concern | Other |
Ambulatory mental health data

Data source: The mental health ambulatory data was extracted from Health Information Exchange on 26 Nov 2014.

Notes:
- The data includes mental health person and contacts with Drug and Alcohol diagnosis (see diagnosis codes below) at Adult and Older Mental Health Service Teams, disregarding if the diagnosis is primary or secondary diagnosis.
- The Mental Health Service teams for Adult and older people grouping are based on the Mental Health service team’s financial sub program. (Adult service teams’ financial sub program=’C’; Older service teams’ financial sub program=’D’).
- The ambulatory data analysis only includes identified clients’ contacts.
- All figures rounded to nearest whole number.

Rules for summary data:
- Rule for counting number of contact (Client point view):
  - The Ambulatory contact data is distinct by facility_identifier, service_unit_identifier, visit_identifier and contact_sequence_number.
  - For group contacts, the number of contact is counted according to the number of clients in the group contacts.
- Rule for selecting individual client:
  - Unique Client (regardless of client being physically present or not and mode of contact).
  - State unique person identifier (SUPI) is used to count unique client. If SUPI is missing, then local unique person identifier is used, otherwise facility_identifier+personal_identifier is used to count unique client.

Drug and Alcohol diagnosis is used for grouping Drug and Alcohol person: Drug and alcohol Codes as below:
- F11.0-F11.9 (grouped) Mental and behavioural disorders due to use of opioids
- F12.0-F12.9 (grouped) Mental and behavioural disorders due to use of cannabinoids
- F13.0-F13.9 (grouped) Mental and behavioural disorders due to use of sedatives or hypnotics
- F14.0-14.9 (grouped) Mental and behavioural disorders due to use of cocaine
- F15.0-F15.9 (grouped) Mental and behavioural disorders due to use of other stimulants, including caffeine
- F16.0-F16.9 (grouped) Mental and behavioural disorders due to use of hallucinogens
- F17.0-F17.9 (grouped) Mental and behavioural disorders due to use of tobacco
- F19.0-F19.9 (grouped) Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances

Alcohol-related pathologies, including the following codes (grouped): G31.2 Degeneration of nervous system due to alcohol; G72.1 Alcoholic myopathy; I42.6 Alcoholic cardiomyopathy; K70.0 Alcoholic fatty liver; K70.1 Alcoholic hepatitis; K70.3 Alcoholic cirrhosis of liver; K70.4 Alcoholic hepatic failure; K70.9 Alcoholic liver disease, unspecified; K85.2 Alcohol-induced acute pancreatitis; K86.0 Alcohol-induced chronic pancreatitis.

Inpatient mental health data

Data Source: The mental health hospital inpatient data was extracted from Health Information Exchange on 26 Nov 2014.

Notes:
- The data includes separations from the designated adult and older mental health wards with Drug and Alcohol diagnosis (see diagnosis codes below).
- The designated mental health wards are defined from the mental health ward table that is maintained by InfoMH.
- All figures rounded to nearest whole number.
- Please be aware that some LHD without any episode cases at some periods means that these LHDs without Adult or Older people service teams available at the periods.
Drug and Alcohol diagnosis used for the data analysis as below:

- F10.0-F10.9 (grouped) Mental and behavioural disorders due to use of alcohol
- F11.0-F11.9 (grouped) Mental and behavioural disorders due to use of opioids
- F12.0-F12.9 (grouped) Mental and behavioural disorders due to use of cannabinoids
- F13.0-F13.9 (grouped) Mental and behavioural disorders due to use of sedatives or hypnotics
- F14.0-14.9 (grouped) Mental and behavioural disorders due to use of cocaine
- F15.0-F15.9 (grouped) Mental and behavioural disorders due to use of other stimulants, including caffeine
- F16.0-F16.9 (grouped) Mental and behavioural disorders due to use of hallucinogens
- F17.0-F17.9 (grouped) Mental and behavioural disorders due to use of tobacco
- F19.0-F19.9 (grouped) Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances

Alcohol-related pathologies, including the following codes (grouped): G31.2 Degeneration of nervous system due to alcohol; G72.1 Alcoholic myopathy; I42.6 Alcoholic cardiomyopathy; K70.0 Alcoholic fatty liver; K70.1 Alcoholic hepatitis; K70.3 Alcoholic cirrhosis of liver; K70.4 Alcoholic hepatic failure; K70.9 Alcoholic liver disease, unspecified; K85.2 Alcohol-induced acute pancreatitis; K86.0 Alcohol-induced chronic pancreatitis.

Hospital service data (no mental health wards)

Data Source: The (no designated mental health) hospital inpatient data was extracted from Health Information Exchange on 31 Oct 2014.

Notes:

- The data includes people who have drug and alcohol diagnosis (see diagnosis codes below) and separated hospital wards (not designated mental health wards), disregarding if the drug and alcohol diagnosis are Primary or secondary diagnosis in the hospital stays.

- The designated mental health wards are defined from the mental health ward table that is maintained by InforMH.

- Hospital bed (ward) type grouping is below. Please be aware that due to data quality issue some wards have been recorded as having multiple bed types.

- In a hospital stay (separation), if the person has been admitted at multiple wards (bed types) in the hospital stay, then the hospital stay is grouped into Multiple Wards.

- All figures rounded to nearest whole number.

Drug and Alcohol diagnosis (primary and secondary) used for the data extracting as below:

- F10.0-F10.9 (grouped) Mental and behavioural disorders due to use of alcohol
- F11.0-F11.9 (grouped) Mental and behavioural disorders due to use of opioids
- F12.0-F12.9 (grouped) Mental and behavioural disorders due to use of cannabinoids
- F13.0-F13.9 (grouped) Mental and behavioural disorders due to use of sedatives or hypnotics
- F14.0-14.9 (grouped) Mental and behavioural disorders due to use of cocaine
- F15.0-F15.9 (grouped) Mental and behavioural disorders due to use of other stimulants, including caffeine
- F16.0-F16.9 (grouped) Mental and behavioural disorders due to use of hallucinogens
- F17.0-F17.9 (grouped) Mental and behavioural disorders due to use of tobacco
- F19.0-F19.9 (grouped) Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances

Alcohol-related pathologies, including the following codes (grouped): G31.2 Degeneration of nervous system due to alcohol; G72.1 Alcoholic myopathy; I42.6 Alcoholic cardiomyopathy; K70.0 Alcoholic fatty liver; K70.1 Alcoholic hepatitis; K70.3 Alcoholic cirrhosis of liver; K70.4 Alcoholic hepatic failure; K70.9 Alcoholic liver disease, unspecified; K85.2 Alcohol-induced acute pancreatitis; K86.0 Alcohol-induced chronic pancreatitis.
### Table 6: Hospital bed type grouping (excluding designated mental health units)

<table>
<thead>
<tr>
<th>Bed grouping</th>
<th>Bed type and description</th>
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<tbody>
<tr>
<td><strong>D&amp;A Beds</strong></td>
<td>07 Drug and Alcohol</td>
</tr>
<tr>
<td></td>
<td>26 Hospital in the Home – Drug and Alcohol</td>
</tr>
<tr>
<td></td>
<td>30 Collaborative Care Service Provider – Drug and Alcohol</td>
</tr>
<tr>
<td></td>
<td>61 Detoxification</td>
</tr>
<tr>
<td></td>
<td>70 Drug and Alcohol Community Residential</td>
</tr>
<tr>
<td></td>
<td>74 Same Day Drug and Alcohol</td>
</tr>
<tr>
<td></td>
<td>88 Justice Health Clinical Observation Bed</td>
</tr>
<tr>
<td></td>
<td>89 Drug and Alcohol Involuntary Treatment Bed</td>
</tr>
<tr>
<td><strong>Aged Care</strong></td>
<td>09 Confused &amp; Disturbed Elderly (CADE) – Non Psychiatric</td>
</tr>
<tr>
<td></td>
<td>14 Residential Aged Care – High (Nursing Home)</td>
</tr>
<tr>
<td></td>
<td>23 Residential Aged Care – Low (Hostel)</td>
</tr>
<tr>
<td></td>
<td>57 Aged and Disability Social Day Program</td>
</tr>
<tr>
<td></td>
<td>83 Residential Aged Care, Not Further Defined</td>
</tr>
<tr>
<td><strong>Medical</strong></td>
<td>46 Medical</td>
</tr>
<tr>
<td></td>
<td>87 Medical Assessment Unit (MAU)</td>
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<tr>
<td><strong>Surgical</strong></td>
<td>47 Surgical</td>
</tr>
<tr>
<td></td>
<td>67 Operating Theatre/Recovery</td>
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<tr>
<td><strong>Rehabilitation</strong></td>
<td>02 Rehabilitation</td>
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<tr>
<td><strong>Emergency Department</strong></td>
<td>17 Emergency Department – Level 3 and Above</td>
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<td>58 Emergency Department – Level 1 or 2</td>
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<td></td>
<td>59 Emergency Medical Unit (EMU)</td>
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<tr>
<td><strong>Other Beds</strong></td>
<td>01 Mixed Purpose</td>
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<tr>
<td></td>
<td>03 Palliative</td>
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<td>08 Brain Injury Rehabilitation</td>
</tr>
<tr>
<td></td>
<td>15 General Intensive Care</td>
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<td>16 Neonate Special Care Nursery</td>
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<td>18 Mother Craft</td>
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<tr>
<td></td>
<td>25 Hospital in the Home – General</td>
</tr>
<tr>
<td></td>
<td>29 Collaborative Care Service Provider – General</td>
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<tr>
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<td>33 Coronary Care</td>
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<td>34 High Dependency Care</td>
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<td>37 Neonatal Intensive Care</td>
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<td>41 Severe Burns</td>
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<td>49 Obstetrics</td>
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<td>51 Respite – High: Federal Government Block Funded</td>
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<td>52 Respite – Low: Federal Government Block Funded</td>
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