OLDER PEOPLE'S DRUG AND ALCOHOL PROJECT

SUMMARY REPORT

NSW GOVERNMENT | Health

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Acknowledgements

Glossary and Acronyms

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
- SBIRT   Screening, brief intervention, and referral to treatment
- SMHSOP   Specialised Mental Health Services for Older People
- US   United States
- WHO   World Health Organisation

Introduction

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 this summary report is to provide a concise version of the full report and recommendations resource for services. The third resource, the 'report in brief' document 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). 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 nonmedical purposes (Hunter & Lubman, 2010). 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. 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). 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; RCPsych, 2011). 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 (Gfroerer, Penne, Pemberton & Folsom, 2003). The baby boomer generation has used different substances and more alcohol and have different habits to previous generations, and when 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).

As an example, estimates of national and state prevalence of risky drinking/alcohol misuse among older people in NSW are between 6% and 16%. Based on 2012 NSW population for people aged 55+, these figures equate to between 115,650 and 308,400 at-risk drinkers. Whilst not all of those risky drinkers will need specialist treatment, NSW Health drug and alcohol and mental health services are only seeing a small proportion of older clients with alcohol diagnoses, which tends to support the project theme of under-recognition, and the need for integrated, inter-sectoral work in the area.

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. The National Centre for Education and Training on Addiction (NCETA) is initiating a national collaborative network, due to meet for the first time in 2015, and some other states are producing work and initiating responses to the growing needs of older people with substance misuse issues.

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;* and 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 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 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 stakeholders from across sectors, consumers and carers and other key stakeholders to scope the needs of older people in relation to drug and alcohol service delivery and existing responses.
- Documenting the 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.
- Identifying the emerging needs of older people within existing drug and alcohol and mental health programs, such as the NSW Opioid Treatment Program (OTP) and other relevant initiatives.
- Identifying key elements of coordinated and integrated care for the population group.
- Exploration of the service models, service responses and service development opportunities which may be appropriate for the target group.
- Preparation of the full *Project Report* and this associated *Summary 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.

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.

There has been considerable discussion in project processes regarding definitions of the project's target population. The agreed target group definition developed in consultation with the EAG, and broadly supported in consultation processes, is people aged 50 years and over. 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. 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.

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 is associated with social engagement across ages, which can be important in older ages when social roles can change and isolation is a higher risk (Wilkinson & Dare, 2014). Social engagement and socialisation are complex in relation to older people's alcohol use. A lack of social engagement can play a role in, or precipitate, alcohol misuse or disorders. Many older people may choose to use alcohol for positive and social reasons, as with other age groups. Some studies reviewed in the project identified older adults often report self-medicating motivations for engaging in alcohol consumption. These included drinking to reduce pain, because of a meaningless life, anxiety, depression, loneliness and sleep problems (Aira, Hartikainen & Sulkava, 2015; Johnco, Draper & Withall, 2015).

As people age, physiological changes impact on tolerance to alcohol, and may cause higher sensitivity and decreased ability to metabolise alcohol (Johnco, Draper & Withall, 2015). Alcohol misuse is tied to depressive disorders, and is associated with a variety of medical problems and increased rates of suicide, falls and cognitive impairment in older people. There are no safe drinking guidelines for older people in Australia. International guidelines vary but rarely support more than one standard drink per day.

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.

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, being the first generation to take these existing habits forward into later life. The only age groups that showed a significant increase in cannabis use in the latest National Drugs Strategy Household Survey were all older people (AIHW, 2014b).

Additionally, many longer term clients of drug and alcohol programs, particularly those accessing Opioid Pharmacotherapy Treatment (OPT), are ageing. There has been an increase in older people receiving pharmacotherapy for opiate dependence in Australia. From 2006 to 2014 the proportion of clients aged 50 and over more than doubled (from 8% to 21%) (AIHW, 2015). Opioid death rates in Australia increased from 15 per million to 30 per million between 2001 and 2005 in older age groups, likely from a combination of illicit heroin use and from misuse of pharmaceuticals (Holmwood, 2011).

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.

Older people misusing opioid analgesic medication for pain management has contributed to an increase in deaths from heroin and other opioid drugs, as noted above in 'illicit 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). Data from the Sydney Medically Supervised Injecting Centre (MSIC)

demonstrates the increasing proportion of presentations from people aged 50 and over with pharmaceuticals as the primary drug of concern. This is included in section 2 of the full report. A NSW study of older drug and alcohol service users found a high proportion of older Opioid Substitution Therapy (OST) clients reported alcohol and benzodiazepine (prescribed or illicit) use (Lintzeris et al, 2015).

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.

Specific populations include Aboriginal people; those who experience abuse; people living in rural and remote areas; people who are homeless or those who are at risk of becoming homeless; people with concurrent mental health problems; older prisoners; people living with HIV/AIDS; people who are lesbian, gay, bisexual, trans/transgender and intersex people and other sexuality and gender diverse people (LGBTI); culturally and linguistically diverse (CALD) communities, and older adults with intellectual disabilities. There is limited evidence available on the needs and practice principles relevant to these populations, although consulted stakeholders have highlighted relevant issues and potential practice strategies.

Comorbidities or multiple morbidities are common in older people with substance use issues. 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). This can be problematic for the older person and for the services providing their care, with the potential for conflict regarding which services should be responsible for coordinating care. Primary comorbidity groupings include substance misuse co-occurring with mental health issues,

and/or with physical health issues, in a variety of combinations.

Cognitive impairment occurs at higher prevalence for the older people with substance use issues and can impact on engagement with services and the capacity of services to respond. Later middle-aged survivors of substance misuse 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 substance related cognitive impairment in older patients has been little explored, and it is noted cognitive impairment can impact on ability to access and maintain engagement with services, and has implications for the design of drug and alcohol services.

Sub-optimal management of pain is a particular issue for sub groups of older people with substance use issues, in the context of prescription opioid use, illicit opioid use, and self-medication with alcohol.

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. Cognitive impairment can create difficulties for people in accessing and maintaining engagement with services. Stakeholders also reported difficulties accessing neuropsychology assessment and the lack of appropriate screening tools to identify older people with substance use issues.

Themes related to ageism, recognition, therapeutic nihilism, and stigma were identified at each consultation workshop. Within older populations there can be low recognition that there is a problem with their level of substance use, or low health literacy and access to self-help resources. Additionally, there are low rates of recognition among health staff due to the wide variety of presenting problems and conditions, and particularly in the context of indirect presentations such as falls or physical health issues, secondary to substance misuse. Distinct from 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. Stigma regarding substance abuse was reported amongst older people, 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 may impact on detoxification. Chronic respiratory disease was further cited as a significant health issue for the older people with substance use issues, likely related to elevated rates of smoking. Medication issues were identified, including those related to pain and pain management, medication interactions with alcohol, and prevalence and management of multiple medications.

Issues including 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. Financial difficulties related to being reliant on a pension and/or the cost of 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. 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.

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.

Social isolation is an issue for many older people with substance use problems and there are complex and interrelated factors. These are related to finances, mobility and transport, engagement, stigma and recognition. For some older people alcohol can promote social inclusion, adding to the complexity of the issue. 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 that 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 scored high in the area of social isolation on the Lubben Social Network Scale (Lintzeris et al, 2015).

Stakeholders reported a range of issues related to the engagement of carers in drug and alcohol services. It was noted that 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. 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.

Services and Service Issues

There is limited research on treatment for older adults 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, in that older patients respond to treatment at least as well as younger patients in terms of adherence and outcomes, and in some cases can have better outcomes (Keurbis & Sacco, 2013; RCPsych, 2011).

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 of the full report, with full details in Appendix B.

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 of the full report. The data supports the perception of increasing service use and need with the arrival of the baby boomer generation in the target age range.

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

Figure 1 demonstrates that there has been a steady increase in drug and alcohol service utilisation for the 50-64 age group, with a moderate increase in closed treatment episodes for those aged 65+.

Figure 1: NSW Health drug and alcohol services – Client type each year by age, across the ten year period July 2004 – June 2014
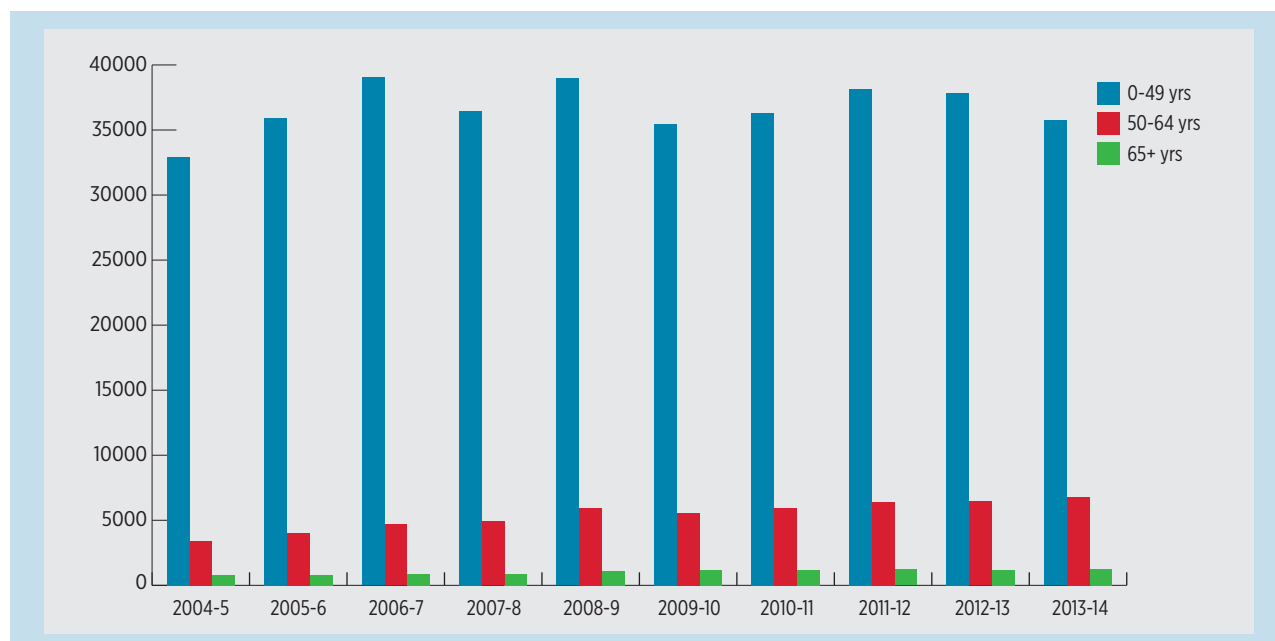
As age increases, there is a marked reduction in the numbers of people who are seen in drug and alcohol services (see Figure 2). People over the age of 65 make up a very low proportion of episodes of care and when they are seen, it is more likely to be in the context of general hospital inpatient settings rather than in outpatient settings or drug and alcohol beds.

Figure 2: NSW drug and alcohol services – number of episodes of care by year, and five year age stratification, for clients aged 50+, across the ten year period July 2004 – June 2014
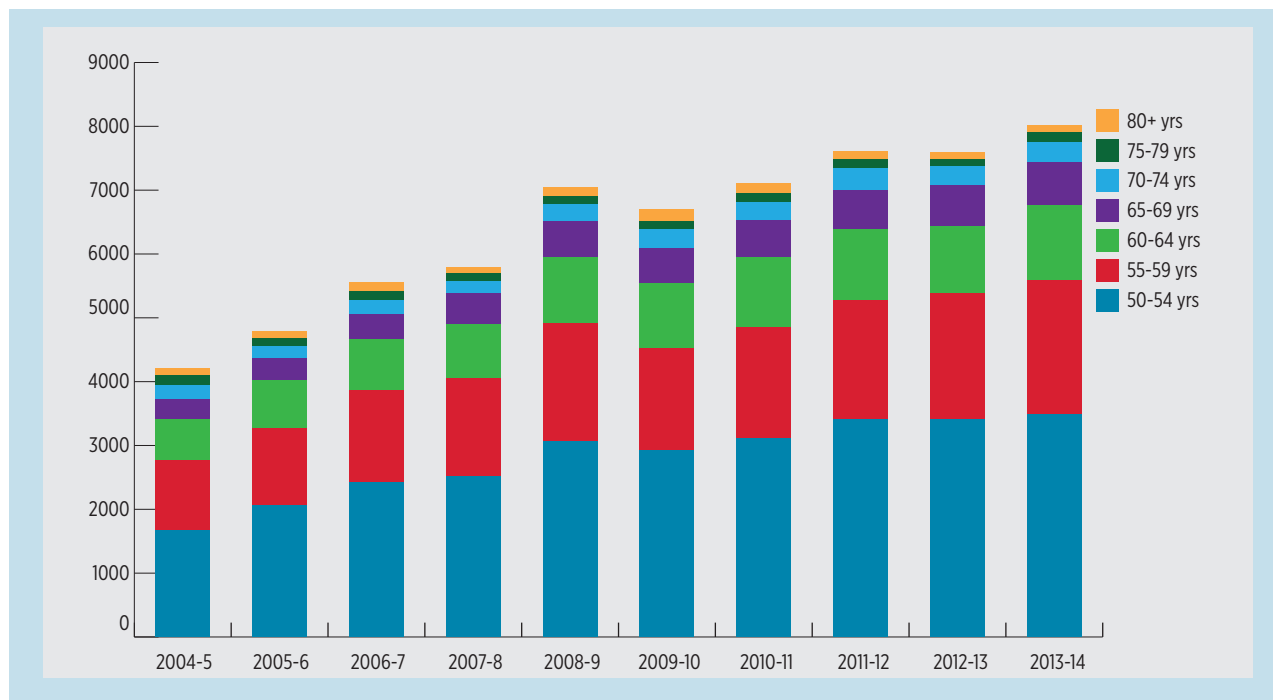
The hospital data demonstrates a substantial increase since 2011 in those over the age of 65 with a drug or alcohol diagnosis in hospital medical, rehabilitation and multiple wards, and most of this is due to alcohol. As a proportion of all those receiving care in drug and alcohol services, the numbers of people over the age of 50 are increasing, while the numbers of people younger than 50 are 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. This pattern is also seen in mental health inpatient units, and is being largely driven by increases in treatment of people aged 50+ for opioids, cannabinoids and cocaine, 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 (bearing in mind the older clients of the OTP, reported separately). 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 or alcohol diagnosis who are 50 years or older. The biggest increase has been in those aged 50-59 years. The mental health service utilisation data suggests that relatively more of the 65+ age group with drug or alcohol diagnosis are seen in ambulatory rather than inpatient services. This may reflect the better access to mental health services as compared to drug and alcohol services for those over 65 years. This may be related to mental health services having SMHSOP that focus efforts on addressing barriers for older people.

Figure 3 demonstrates that adult ambulatory mental health services show a clear trend of increasing numbers of clients with drug and alcohol diagnoses in the younger old age groups (50-64 years), supporting the notion of generational changes. Whilst the numbers of people aged 50+ with a drug and alcohol diagnosis in the SMHSOP community teams are low and more variable, they are also trending up, as per Figure 4.

Figure 3: NSW Health Mental Health services – numbers of unique clients each year with adult ambulatory mental health teams with a drug and alcohol diagnosis, for each 5 year age group, across the ten year period July 2004 – July 2014
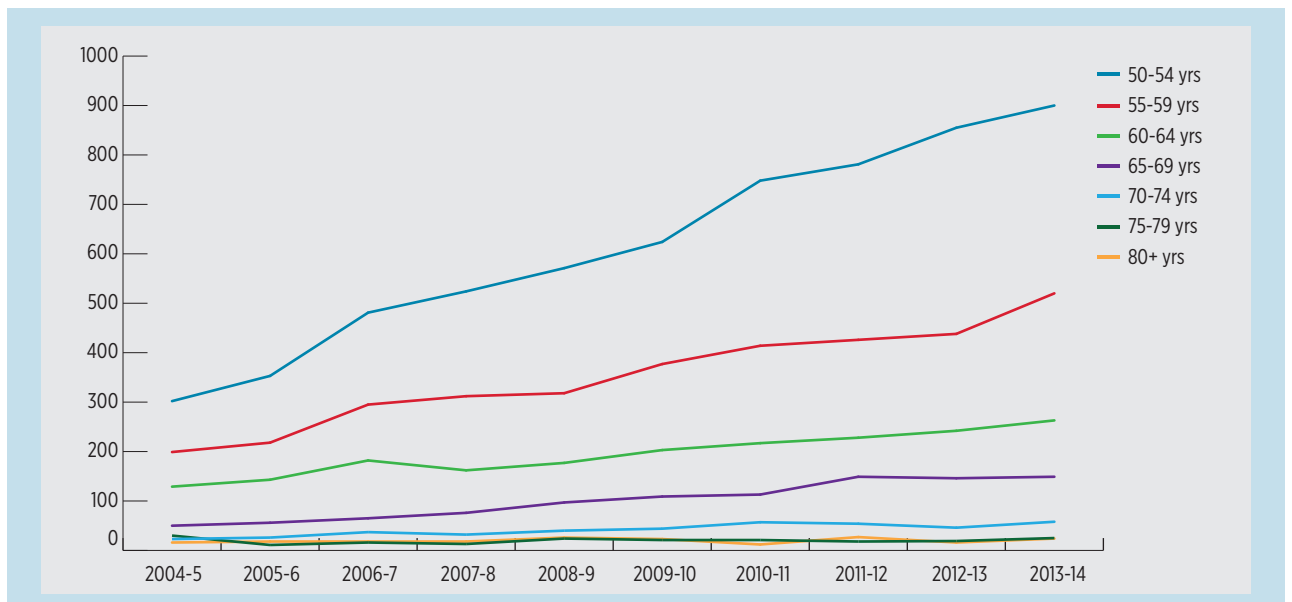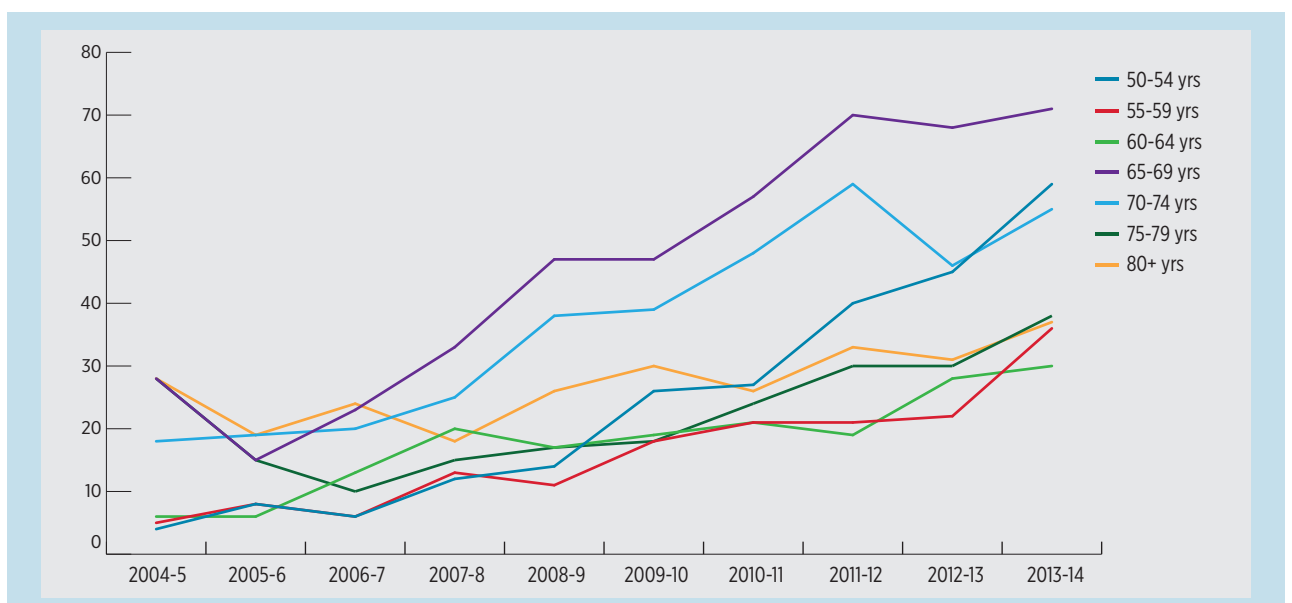

Figure 4: NSW Mental Health services – numbers of unique clients each year with ambulatory SMHSOP teams with a drug and alcohol diagnosis, for each 5 year age group, across the ten year period July 2004 – July 2014

The pattern of substance use amongst older service users is significantly different between those in drug and alcohol services and those in mental health services. 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. 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 in 'multiple bed types' prior to a hospital discharge, or may be seen across a range of other bed types. This supports the project themes regarding the need for better inter-sectoral relationships and collaborative models. It is going to 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 Hospital Addiction Medicine Clinic (page 12) 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, as 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, have recently been mostly seen in adult mental health inpatient services, and drug and alcohol ambulatory services.

Barriers to service access

The primary identified barriers to service access by older people with substance use issues are recognition and stigma.

Low rates of recognition, both in terms of older people recognising that there may be a problem, and amongst health care workers, is a significant barrier to accessing services. Limited understanding among health professionals of the range of services available and their referral systems was commonly raised as an issue by consulted stakeholders. This barrier is described further in the workforce section. Stigma, shame, and embarrassment are significant for both long term substance abusers, such as those in the 'younger old' cohort, and for

members of the 'older old' cohort with issues being detected for the first time.

The consultations also raised issues related to carer involvement. Carrying out individual assessment can be disengaging for families, and the challenge is to find a balance between engaging families, protecting consumer rights to privacy, and minimising the risk of under-disclosure through stigma and shame in carers' presence.

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.

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.

Responses to consultation questions 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.

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

Particular needs of drug and alcohol sector staff highlighted include: 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.

Training and development needs for the mental health workforce include being 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. Consideration needs to be given to 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 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.

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. When consumers are in hospital, stakeholders reported engagement in services is often better, noting the DACL role as instrumental in this.

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 meaning other options need to be utilised, 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.

It was reported by consulted stakeholders 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.

Clinical processes and service delivery arrangements that work

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. 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.

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 are adjusted for older people, they may be more efficient and improve outcomes in comparison to mixed age treatments. The age-specific components in the studies 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.

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.

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. 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 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.

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.

The Alcohol Use Disorders Identification Test (AUDIT) (Saunders et al, 1993) was developed by the World Health Organisation (WHO) as the gold standard screen for hazardous and harmful alcohol use. It has been found to have low sensitivity among older adults, although this improves with lowered cut off points (Aalto et al, 2001; Berks & McCormick, 2008; Draper et al, 2015). As a brief screening measure, the 3-item AUDIT-C (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.

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 Aboriginal Drug and Alcohol Network (ADAN) members by the Aboriginal Health and Medical Research Council (AH&MRC) of NSW. 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 high prevalence of cognitive impairment among older people with substance use issues. There are a multitude of cognitive screens available, and local consistency with referral partners is important. Key screening options are included in the recommendations.

Another emerging issue for drug and alcohol services as they start to see more older people 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.

CLINICAL PRACTICE: 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. Much of the literature detailed in the full report (Section 3B) relates to one randomised trial conducted in the US, the PRISM-E study, and most randomised controlled studies (RCTs) identified for review in Keurbis & Sacco (2013) and Kok (2014) relate to alcohol, and are limited by small sample sizes. They also relate to older adults who were seeking treatment, and further research is required regarding accessing those who are not seeking treatment or advice. There is, however, a growing awareness of the need to develop improved responses, and professional opinion reports from respected sources are increasing in number, such as that from the UK Royal College of Psychiatrists (2011). The available evidence is summarised as follows:

- Keurbis and Sacco (2013) summarise the results of 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. The studies did not contain true control groups and it cannot be definitely concluded what outcomes can be attributed to the treatment, or which treatments were more effective than others
- The thirteen studies on age-specific treatments 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 adaptions to treatment included group therapy with topics relevant to life stage, such as coping with loss, grief, loneliness and life transitions (Keurbis & Sacco, 2013).
- The PRISM-E trial involved older adults being screened for alcohol use in a primary care setting (i.e. those who were not seeking treatment) and either receiving integrated care (brief interventions on site at primary care clinic), or specialist referral. Both groups experienced improvements, but alcohol users who received the integrated care had better engagement and were twice as likely to stay in treatment (average 1.42 visits vs. 0.78 visits) (Keurbis & Sacco, 2013). However, there were no differences between groups at six months (Oslin et al, 2006).
- 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. Studies reviewed by Keurbis & Sacco (2011) demonstrate 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.

Broader Strategic Issues

Population health issues and service interfaces

Although the focus 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 needs of older people with drug and alcohol issues, particularly those related to recognition of substance misuse issues.

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. Recent developments in the area include a series of fact sheets produced by NCETA: the 'Grey Matters' factsheets (links included in full report at Appendix C) 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 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.

Aged care interface and accommodation issues

Whilst not the focus of this project, the need for appropriate supported accommodation and support options for older people with drug and alcohol issues, including residential aged care, has been raised as a significant issue. Stakeholders identified there is a need for a variety of accommodation options to be available for the older people with drug and alcohol issues 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.

In addition to the accommodation needs of older people with drug and alcohol issues, 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

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 and ideas for research include:

- Epidemiological research regarding 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 sub-groups 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, and
  – 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.

Summary and Recommendations

In summary, this report (and the full project 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 noted 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 equally well to younger cohorts to (mixed aged) treatments, and that more treatment through longer 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 the Mental Health and Drug & 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 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 of the full report.

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 the 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 of the full report 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:
  - i. The Arbias Acquired Brain Injury Screen (in CHOC)
  - ii. The Montreal Cognitive Assessment (MoCA)
  - iii. 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 adaptions 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 (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.

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