Dual Diagnosis

Victorian Dual Diagnosis Initiative

BUDDHAS - Building Up Dual Diagnosis in Holistic Aged Services

Older Adults Dual Diagnosis Resource Guide

2015

Developed by the Victorian Dual Diagnosis Initiative

November 2015

Acknowledgements

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This project also represents an important collaboration with Peninsula Drug and Alcohol Program, Older Wiser Living Service, St Vincent's Aged Mental Health Service, Banyule Community Health Service, and cohealth.

Thanks also to the VDDI managers for enabling staff to contribute to the development of the manual. Thanks to Glen Davis (cohealth) for initial contributions to editing and to Maria Yap and Lara Jackson. Special thanks to Dr Caroline Clark who provided substantial and final edits. Thanks to Gary Croton for always keeping everyone up to date on issues related to older adults, AOD use and dual diagnosis.

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Table of contents

Introduction

What's important in dual diagnosis and older people

This guide covers key practice areas for practitioners working with older adults who have a dual diagnosis – a co-occurring alcohol and other drug (AOD) use and mental health problem.

The guide has been produced in response to increasing calls from services for information on working with people aged 55 years and older with a dual diagnosis. Research literature and clinical experience both indicate how complex dual diagnosis can be, and this is further complicated by the ageing of the baby boomer generation which will bring a more complex dual diagnosis profile. Within mental health, those aged 55-64 are still in adult services and can present with complex issues. In the coming years they are likely to present in aged psychiatry (and other related services) with a more complex profile [1]. Primary care services are also important for identifying and responding to service users with a dual diagnosis as many older adults also access these services for physical health care.

What's in the guide

The guide has five practice topics:

1. **What about older adults and dual diagnosis?**
2. **Screening and assessment**
3. **Biomedical interventions**
4. **Psychosocial interventions**
5. **For carers**

Where possible, the information provided is specific to older adults with a dual diagnosis. Nevertheless, as this is a developing field, general dual diagnosis information (usually based on research with adults) is provided, as is information on AOD use and mental health issues among older adults that might not necessarily be in the context of dual diagnosis.

We don't yet know a great deal about a broad range of interventions for dual diagnosis, let alone older adults with dual diagnosis; what we do know is that, considering complexity and various impacts on those experiencing these issues, providing integrated treatment for people with a dual diagnosis is standard good practice. Other aspects of good practice are recognition of problems via routine screening and assessment, taking a strengths focus, being welcoming and engendering hope, and fostering social connection to promote recovery. We know that change can happen – it's never too late.

Who it's for

This guide is intended to guide and support practice in working with those who are aged 55 and older with 'dual diagnosis'. It is intended as an adjunct to professional, inter-collegial and where appropriate supervised practice, and is not meant to replace professional judgement.

We encourage clinicians working with older adults to further develop their interest, knowledge and skills in working with older adults with dual diagnosis. Clinicians should be curious and ask questions regarding the use of a range of substances and a variety of mental health concerns. The objective of the guide is to provide an overview of screening, assessment and interventions for older adults with a dual diagnosis.

While practice is discussed in the context of Victorian service systems and legal frameworks, the broader points are relevant for practitioners working in other places.

Where it's come from

The guide has been developed by the special interest group Building Up Dual Diagnosis Holistic Aged Service – 'BUDDHAS' – many of whose members work in the teams that make up the statewide Victorian Dual Diagnosis Initiative (VDDI). It represents the collective practice wisdom of the group and is based on recent evidence regarding older adults and dual diagnosis and good practice in this area.

About BUDDHAS

BUDDHAS aims to provide direction in the development of dual diagnosis service delivery to aged persons services in Victoria. BUDDHAS is committed to the improvement of health outcomes for aged persons with co-occurring mental health-AOD use problems, through establishing a coordinated service delivery approach.

About the VDDI

The Victorian Dual Diagnosis Initiative (VDDI) is a cross-sector (alcohol and other drug, mental health community support and clinical mental health) initiative funded by the Victorian Department of Health & Human Services. The VDDI's role is to contribute to the further development of mental health and AOD workers', agencies' and sectors' capacity to recognise and respond effectively to people experiencing co-occurring mental health and AOD use concerns ('dual diagnosis').

1. What about older adults and dual diagnosis?

The 'baby boomer' generation (those born between 1946 and 1964) is growing older – people born in 1946 turned 65 in 2011 – and this generation is more likely to have alcohol or other drug problems than previous ones. This is one of the reasons attention is turning to older adults with a dual diagnosis.

Why should we care about dual diagnosis in older adults?

Impacts of dual diagnosis in older people

The impacts that older adults with a dual diagnosis are likely to experience will be different from those that younger people do: these include decreased tolerance, increase in adverse interactions with medications, and increased risk of falls, injuries and suicide.

Older people have the highest suicide risk of all age groups, and there is an association between alcohol consumption and suicide in older people, as well as some evidence that risk of suicide associated with alcohol dependence increases with age. Comorbid depression and alcohol problems present a particular risk. When depression worsens, alcohol use often increases and because alcohol lowers impulse control, risk of suicide increases [2]. Similarly, the disinhibiting effects of benzodiazepines increase the risk for suicide (in one study, benzodiazepines were involved in 39% of drug poisoning suicides in the elderly [3]).

The National Health and Medical Research Council's 2009 *Australian Guidelines to Reduce Health Risks from Drinking Alcohol* identify older adults as a particular risk group when it comes to drinking (this is for levels of drinking above the 'light to moderate' amounts that are possibly protective for some chronic conditions that are prevalent in older age [4]).

Dual diagnosis looks different in older people

What we know about younger adults does not always apply to the older population. There are several age-specific factors that increase an older adult's likelihood of experiencing both problematic AOD use and mental disorders: retirement, loss of mobility and associated independence, medical illness, grief, social isolation, and identity issues and role confusion.

Older adults can be vulnerable simply because of their stage of life. In relation to AOD use, older adults tend to:

- use for different reasons, such as relief from grief or pain
- use in different ways, e.g. at home, and daily. This can include sharing medications with friends to relieve symptoms they have in common, which can lead to problems of taking medications that have not been prescribed and could be contraindicated
- feel shame which holds them back from seeking help for AOD use problems

At the same time, we know that older adults with AOD use problems, or with dual diagnosis, do well in treatment.

More problems as baby boomers age

Compared with the previous generation of older adults, a larger proportion of baby boomers have AOD use and mental health issues. They also hold more liberal attitudes towards alcohol, prescription medicines and illicit drugs, and use them at higher rates. (In one study, some adults aged 55-64 had a history of injecting drugs, while none aged 65 years or older did [1].) Therefore, increased rates of associated problems can be expected, leading to rising demand on services by older people with complex presentations, including current drug use problems and dual diagnosis.

There is however little research into older adults' current and/or previous use of illicit drugs and the implications of this. And there is even less research that focuses on drug use in the context of mental illness in this age group. The research that does exist suggests that among baby boomers there is probably more AOD use, and greater variety of drugs used, along with continuing use. This means we can anticipate:

- higher rates of dual diagnosis, due to ongoing AOD use and problems, than in the previous generation of older adults
- residual effects from illicit drug use when they were younger, such as acquired brain injury and blood-borne viruses

Myths and misconceptions about older people with dual diagnosis

Common myths and misconceptions about dual diagnosis in older people mean that problems are not recognised and treatment is seen as futile. This can impede successful treatment.

Treating older adults is too hard. Anyway, is it needed?

These are some common misconceptions about older people which can hinder provision of treatment:

- Drug use is temporary and linked with a current stressor or physical health complaint (insomnia, pain, increased anxiety, grief or loss issue)
- Medications cannot be addictive or cause other problems because they have been medically prescribed or are available 'over the counter'
- Alcohol cannot be a problem because 'alcohol is good for heart disease'
- Older clients are too old to change their ways or patterns of behaviour; they are 'untreatable'
- Treatment is not warranted in older age – 'let them enjoy their last days' – although people may live for years and decades yet

In fact, older people may be easier to treat

Contrary to common belief, older people can be easier to treat: they are more likely to have stable housing, regular income, long term relationships with others and be linked with a general practitioner who knows them well. In addition, they often have better insight into what does or doesn't work for them.

What does dual diagnosis look like in older age?

Signs and symptoms linked to dual diagnosis are different across the lifespan. They will also change over time as there are changes in treatments, medications and trends in AOD use.

Some of the common signs of dual diagnosis in older age are:

- increased anxiety
- unsteady gait and poorer balance
- lower mood or significant changes in mood
- increased physical health problems and gastrointestinal problems (particularly with alcohol)
- increased isolation
- decreased appetite
- increased incontinence
- increased falls
- poorer memory/ alcoholic blackouts
- dehydration

Trends in older adults' use of alcohol and other drugs

Drugs being used

Alcohol

Currently, older Australians are more likely than the overall adult population to be drinking alcohol daily. This is despite a greater proportion of people aged 60 or older not drinking alcohol at all. The proportion of people drinking at a risky level in the 50-59 and 60-69 age groups is similar to the rate in the general population, and is much lower in the 70+ age group (see Table 1).

Table 1. Alcohol drinking status, frequency and consumption among older Australians and all Australian adults, 2013 [5]

Age group	Abstainers (%)	Drink daily (%)	Risky drinking (%)*
50-59	19.0	9.0	20.1
60-69	24.4	12.4	18.6
70+	40.3	14.7	10.1
All ages 18+	22.6	6.9	19.1

* at a level to be at risk of alcohol-related harm over a lifetime [4]

Prescription drugs

Numerous large studies (mostly concerning adults) have shown that dependence on prescription drugs is prevalent among people with dual diagnosis [6-8]; in particular, prescription rates of benzodiazepines among institutionalised elderly patients are high.

Elderly people may have easier access to prescription opioids: use of these drugs by older people is less stigmatised than other opiates, and being bought on prescription reduces costs (especially for those with Pensioner Concession Cards or Seniors Health Cards).

Cannabis

As in the population as a whole, cannabis is the most widely used illicit drug among older adults [5]. Use typically declines throughout adulthood, although some people start or recommence its use at an older age for its potentially positive effects on stress, appetite and pain.

Opioid pharmacotherapy

Australian statistics indicate that, as in other countries, there is an ageing cohort of people receiving opioid pharmacotherapy treatment. This may be due to some clients remaining in treatment for decades, or clients seeking treatment for the first time at an older age [9].

Increasing prevalence of illicit drug use

More older people using

The proportion of older adults who are using illicit drugs has been steadily increasing, while in the population as a whole prevalence has remained about the same: the proportion of people in their 50s who had used an illicit drug in the previous 12 months increased from 4% in 1995 to 11% in 2013, and among people 60 and older, from 3% to 6% [5].

Similarly, use of pharmaceuticals for non-medical purposes has increased more among older adults than in the whole population [5].

… And using more regularly

When we look at how often people currently in their fifties use illicit drugs, it is approaching the population average [5]. As this group moves into their sixties and beyond, this will become more common in these older age groups.

The same is the case when we look at non-medical use of pharmaceuticals. While lifetime and last-12-months use is similar across all age groups, use in the previous month and in the previous week is higher among those aged 55 and over [5].

Abstinence

Overall, consumption of alcohol and other drugs generally declines as people become elderly. As shown in Table 1 above, while more older people are daily drinkers (compared with younger people), at the other end of the spectrum, more are also non-drinkers.

Alcohol: physical and mental health risks for older people

As baby boomers age, it is likely that the rate of alcohol abuse or dependence in older adults will increase.

Older adults' physiology

Changes in physiology and metabolism mean that older people are at increased risk of experiencing alcohol-related harms. Lean body mass reduces, so that a given amount of alcohol produces an increase in peak ethanol concentration. Older people also metabolise alcohol less efficiently, so effects can occur more abruptly and take longer to dissipate. This means that cognitive abilities such as reasoning and memory might be more easily impaired.

Effects of alcohol in older adults:

- increased neurochemical and neuronal sensitivity
- decreased excitatory phase, quicker entry to sedative phase with higher peak levels
- increased impairment with same blood levels
- decreased euphoric effects
- decreased capacity to develop tolerance
- aggravation of other illness

Risks of harm

Physical health:

- increased risks of medical comorbidities such as hypertension, diabetes and cancer
- diuresis and orthostatic hypotension, with increased risk of falls
- myopathy and reduced strength
- peripheral neuropathy
- cerebellar damage and ataxia
- osteoporosis and higher age-adjusted rates of hip fracture
- if use is chronic, liver enzyme induction and increased drug metabolism
- increased falls risk and fractures, with or without osteoporosis

Cognition

- delirium in withdrawal
- Wernicke's encephalopathy (acute confusion, incoordination and double vision)
- Korsakoff's syndrome (isolated memory impairment)
- alcohol-related dementia: global cognitive impairment, cerebral atrophy

Mood

- depression: heavy alcohol use and alcohol dependence are associated with high rates of depression
- sleep disturbance

Risks from concurrent use of alcohol and other medication

Alcohol use is associated with increased likelihood of poly-pharmacy, which brings further risks:

- interaction of alcohol with prescribed medications (especially important for drugs with a narrow therapeutic index such as warfarin)
- effect on drug absorption
- delayed gastric emptying, increased small bowel transit time
- low albumin levels and effect on protein binding
- effect on drug metabolism:
    - decreased drug metabolism with age
    - fluctuating drug clearance (binge drinking)
- effect on adherence
- concurrent dependence on other drugs such as benzodiazepines

Early or late onset of problematic use of alcohol

Problematic alcohol use in older people is commonly classified according to whether it is early-onset and late-onset. Early-onset use is more common, and refers to drinking problems that began in the person's twenties or earlier, and have progressed and worsened with age. Late-onset drinking typically begins in the person's fifties or later, in reaction to stressful life events such as divorce, loss, loneliness, trauma, retirement or illness [10].

The literature on this topic focuses on alcohol but the insights could be extrapolated to use of other drugs.

Early-onset use

People who develop alcohol problems earlier in life are likely to continue drinking at risky levels. They make up around two-thirds of presentations, are mostly males and are more likely to be from lower socio-economic backgrounds. There is also often a family history of alcohol dependence.

Older adults with alcohol-related disorders that developed earlier on in life are more likely to seek treatment, but are also more likely to present with more complex medical and psychiatric comorbidities resulting from the cumulative effects of drinking over many years.

Older adults with early-onset problem drinking are at increased risk for a number of conditions:

- cognitive deficits from frontal lobe atrophy which occurs with long-term heavy drinking
- postural instability and higher risk of falls from atrophy in the cerebellum due to long-term drinking
- a quadrupled risk of developing functional impairment due to heavy alcohol consumption (five or more standard drinks daily)
- risk of osteoporosis and dementia from heavy alcohol consumption

Late-onset use

Late-onset alcohol problems are less common than early onset ones. Those who present with late-onset problems are more likely to be female and have a higher education level and income. They usually have less marked cognitive deficits and are more likely to have more social support and better family relationships. They can experience better outcomes than those with early-onset problems, but are less likely to seek treatment due to shame and lack of information about services [11].

Or is the distinction not so clear?

What might be considered as 'late onset' problems could in fact have been occurring earlier but not picked up because screening was not routine in health care and primary care services.

Or is it because older people don't tolerate effects of alcohol so well?

Alternatively, perhaps problematic drinking is more noticeable later in life because as people age they generally do not tolerate alcohol very well and experience an increased range of health problems.

Benzodiazepines: dual diagnosis population

The typical patient with problematic benzodiazepine use is an older widowed female with various health problems and psychiatric symptoms, and who is a frequent user of medical services [12]. However, the majority of these patients have never seen a mental health professional.

Effects of benzodiazepines in older adults

Up to 10% of drug-related hospital admissions in the elderly are due to benzodiazepine effects and side-effects, as a result of physical and cognitive effects of the drugs.

Different effects on older adults

- increased sensitivity to side effects
- increased sensitivity of benzodiazepine receptors in the central nervous system (CNS)
- increased side effects in those who have used them regularly over a long period
- decreased drug metabolism leading to prolonged plasma half life

Cognitive effects

- anterograde amnesia (loss of the ability to create new memories), reduced short-term recall, increased forgetfulness
- increased risk with long-acting agents
- increased risk of delirium
- increased cognitive decline (a risk from long-term use)
- improved functioning on drug cessation

Psychomotor impairment

- slow reaction time, decreased speed and accuracy of motor tasks
- increased risk of motor vehicle accidents by 30-50%
- increased risk of falls and increased risk of hip fractures by 50%

Risks

Risk of iatrogenic dependence

Iatrogenic benzodiazepine dependence is a real concern, and regular medication reviews are important for older clients.

Risk of benzodiazepine dependence increases with age

Dependence is more common in elderly people with:

- medical conditions using multiple medications
- depression and alcohol dependence

With the prevalence of insomnia increasing significantly with age, the risk of benzodiazepine dependence likewise increases. Dementia, depression and anxiety syndromes can be a consequence of benzodiazepine dependence.

Elder abuse and AOD use

As with other forms of violence, the risk of elder abuse is increased in the context of harmful AOD use, by both victims and perpetrators.

Besides being at risk of self-neglect, older adults who drink alcohol at harmful levels are vulnerable to abuse. Deteriorating physical health, cognitive impairment and social isolation contribute to this vulnerability. If their AOD problem is long-standing, poor family relationships might mean that family members are unwilling or unable to provide appropriate care.

A carer or relative using alcohol or other drugs at harmful levels increases the risk of their being a perpetrator of elder abuse.

Whether it is victim or perpetrator who is using AOD at harmful levels, abuse can be physical, emotional, or financial (financial abuse is particularly common). The extent of AOD-related elder abuse is unknown, as it is not a well-researched area, especially in relation to drugs other than alcohol [13-16].

2. Screening and assessment

Why should we screen and assess for dual diagnosis?

Although routine screening and assessment for dual diagnosis is warranted, it is not commonly undertaken, and where it is, is often not done well.

The number of older Australians seeking specific treatment for mental health and AOD-related problems is disproportionally low given the estimated prevalence rates [17]. Even though they are likely to be in regular contact with a range of healthcare services which are ideally placed to conduct screening, they can be reluctant to seek treatment for AOD problems, and service providers can be reluctant to ask. Research also indicates that even where screening for alcohol and drug issues in older adults (with or without dual diagnosis) is undertaken, it lacks sensitivity and/or lacks breadth.

Comprehensive bio-psycho-social assessment

Proper diagnosis requires a comprehensive bio-psycho-social assessment. Without proper diagnosis, older AOD users do not receive adequate interventions. Further, in order to understand and intervene appropriately with older adults, an elaborate, person-centred view of dependence is required.

Presumption of other diseases can result in AOD use or dual diagnosis being overlooked. Diseases related to ageing, AOD use and mental health issues can all mask, mimic and exacerbate each other, so again, thorough screening and assessment is essential.

Screening and assessment challenges

Impaired cognition

Consider the impact of cognition on patient's ability to answer questions. It may be necessary to take into account cognitive deficits related to chronic mental illness and/or possible acquired brain injury (ABI) resulting from chronic drinking, nutritional impairment, head injury and/or drug overdoses.

Slowness

If impaired cognition is present, screening and assessment might take longer, might require more than one attempt and might need to be preceded by assessment of cognitive functioning.

An older person's history of AOD use might be quite long, and they might find recalling it more difficult than a younger person. Therefore the process might take longer so patience and perseverance are important.

Shame and guilt about AOD use

There could be guilt and shame which can impact on disclosure. This means it is important to proceed sensitively and respectfully. In addition, older clients might have a fear of being labelled as illicit drug users [1].

Stigma of mental illness

Mental illness can be stigmatizing for this population and older people might not understand what their diagnosis is (if they have one). Consequently, clients may consider physical ailments and stress-related diagnoses to be a 'safer' and 'more acceptable' way of describing or disclosing what might be mental illness [1]. Similarly, the expression of psychological distress as physical symptoms (somatisation) may be culturally sanctioned.

Lack of mobility

Lack of mobility may inhibit older adults from presenting to services. Consider outreach to overcome mobility issues and fear of taking the first step to services.

Helpful approaches

Find the best approach to maintain engagement

We know that welcoming those with a dual diagnosis into services and providing hope from the outset is core to effective dual diagnosis practice. Therefore, the approach to screening and assessment, especially initiating the conversation, is of the utmost importance. Engagement can be preserved by normalising the screening and assessment process, describing it as routine.

Explore whether a more clinical or a less clinical approach suits. Some older clients expect a specialist expert, while others prefer a more casual approach and value a positive social interaction.

Enlist general practitioners to help

Older adults are more likely to go to a GP than younger people, which makes GPs well placed to identify AOD issues in this population. Further, research shows that older adults are more open to GPs' advice regarding risks of continued AOD use, and that a suggestion to change from a GP is an

important factor with older adults who have mental health and AOD use concerns [1]. For these reasons it makes sense to enlist GPs to screen and assess their older patients for AOD and mental health issues.

Listen

Older clients tend to be very willing to engage in dialogue: 'They seem to value a listening ear, the witnessing of their experience' [18, p 20]. With a listening ear, older adults are interested in talking about their AOD use history.

Assume older adults seek and can achieve change

As we saw in Section 1, it is a myth that effort should not be put into treating older people; in fact they are as likely to benefit from treatment as younger people. Contrary to some stereotypes, research has shown that older adults respond well to intervention and even those with long-term alcohol problems may change their drinking if the risks and negative effects are clearly explained.

Increasing awareness of negative effects of AOD use can work better for older adults than for younger people. Ryan [1] found that older people with dual diagnosis recognised that AOD use (and withdrawal) impacts negatively on mental health, and this was a reason they would consider stopping altogether. Further, older people often follow treatment regimens more diligently.

Older adults (as many younger people) may not understand low-risk alcohol intake, and this is an instance where outlining risks can inspire them to change their use of alcohol and other drugs. On the other hand, older adults might already understand some risks – we can check by asking them.

AOD and MH screening and assessment with older adults

General points to consider

Where possible use screens appropriate for older adults

Because older adults are likely to be more sensitive to the effects of alcohol and other drugs (see Section 1), their threshold for hazardous and harmful alcohol consumption is lower.

Further, super-sensitivity – relatively low quantities of alcohol or other drugs can be problematic for people with an existing mental illness – means that particular care needs to be taken with screening. Combined with the possibility of greater sensitivity to effects of alcohol and other drugs due to age, screening for all substances is essential.

For these reasons it is important, wherever possible, to use tools that are appropriate and valid for use among older adults. These are covered below. Currently, there are not a lot of options.

Consider history and patterns of use

As discussed in Section 1, patterns of use are likely to be different in older adults compared with younger drinkers [18]:

- some very long-term use
- also late onset use
- sharing medications with friends or family

And there are also similarities:

- binge (intermittent or pattern)
- self-medicating

Older adults may well have addressed their AOD use in the past, and these previous efforts can provide the basis for a strengths approach to future work.

Screen for residual effects

The residual effects of previous long-term AOD use (for example blood-borne viruses (BBVs) such as hepatitis C) within the baby boomer population may become more evident as they grow older. Prior to the 1990s, awareness of BBVs and strategies to avoid transmission was low.

Therefore, it makes sense that services should screen for these residual effects, although there is no research that indicates screening for residual effects is occurring routinely.

Consider stage of life

Older adults can be vulnerable simply because of their stage of life. Consider age-specific factors that increase an older client's risk of experiencing AOD and/or mental disorders: retirement, loss of mobility or independence, medical illness, grief, social isolation, and identity/ role confusion. If these are occurring, consider screening for AOD and mental health issues. A way to identify such vulnerabilities is to ask broader questions, such as how they are using their time.

Variations between ethnic groups and religious affiliations, along with genetics, are other factors that need to be taken into consideration regarding the development of problematic use of alcohol and other drugs [19].

AOD diagnostic complications

There are also diagnostic complications that are associated with the nature of AOD use among older adults.

AOD use and DSM

It is important to note that many older adults who experience problems associated with their use of AOD might not meet some DSM-5 criteria for substance-related and addictive disorders.

Broader range of substances

Older adults may be using or have used alcohol, benzodiazepines, cannabis, heroin, opioid analgesics, over-the-counter medications and other licit and illicit substances, so broad screening is required. It is important to remain open to the possibility that a client might be using and/or have used a range of alcohol and other drugs, and that this poses residual and/or current risks. Older adults are also more likely to be taking (and possibly sharing) a range of medications. The interaction of these other drugs with alcohol can impact negatively on other illnesses, functional capacity, psychomotor ability and cognition. Again, this points to the need for broad AOD screening and explanation of risks related to interaction of alcohol and other drugs. Specifically ask about taking and/or sharing a range of alcohol and other drugs.

Masking of AOD problems

In older adults alcohol problems can be masked by other conditions associated with age such as memory loss, confusion (particularly for those with dementia), unsteady gait, reduced mobility, poor co-ordination, falls, depression, mood swings which can delay recognition of drinking problem so problems can become more severe [18].

Obtaining collateral information where possible can shed light on the possibility of AOD problems, although caregiver complicity (often unwitting) is always a possibility.

Other signs of AOD problems

Alcohol and other drug problems can lead to self-neglect, with symptoms such as falls, cognitive and affective impairment and social withdrawal [20].

Other factors that may suggest problematic use of alcohol (and to some extent, other drugs):

- not attending appointments or completing treatments
- unstable or poorly controlled hypertension
- recurrent accidents, injuries or falls
- frequent visits to the emergency department
- gastrointestinal problems including liver disease, pancreatitis
- unexpected delirium during hospital admission
- estrangement from family
- heightened emotions and aggravated moods like irritability, depression, anxiety, panic
- abnormal blood tests, for example raised liver enzymes (like GGT) and enlarged red blood cells (MCV)

Domains of comprehensive assessment for older adults

The domains for a drug/alcohol/mental health/dual diagnosis assessment usually include:

- family, relationships, isolation
- enjoyable and/or meaningful activities, activities of daily living
- housing
- employment, retirement
- legal issues
- history of AOD use (amounts, patterns), dependence, reasons for use (as a basis for considering change), assessment of harms (as a base for harm reduction strategies), exploration of previous attempts to stop/ modify and relapse prevention strategies used
- effects of AOD use on mental health and vice versa, history of interventions related to mental health and/or AOD use
- stage of change in relation to AOD use and acknowledgment of mental illness, goals, risk issues
- physical health
- cultural and religious affiliations

As well age-related physical-biological risk factors associated with AOD use, a bio-psycho-social assessment for older adults needs especially to consider older adults' psycho-social risk factors for AOD and mental disorders:

- death of a spouse/ grief
- living alone
- being isolated
- loss of mobility/ independence,
- medical illness
- retirement identity/ role confusion

Older adults are at particular risk of sleep disturbances and alcohol use for pain management.

Summary of screens

Screening tool	Alcohol	Other drugs	Mental health	What it measures	Validated for older population?
ARPS – Alcohol-Related Problems Survey	✓			Identifies low risk, risky and harmful alcohol use	Yes
A-ARPS – Australian ARPS	✓			As above	Yes
SMAST-G – Short Michigan Alcoholism Screening Test – Geriatric Form	✓			Identifies harmful and dependent alcohol use	Yes
CAGE and CAGE-AID	✓	✓		Problem alcohol, AOD use	No
AUDIT – Alcohol Use Disorders Identification Test	✓			Hazardous and harmful alcohol use	No
ASSIST – Alcohol, Smoking and Substance Involvement Screening Test	✓	✓		Hazardous, harmful and dependent alcohol, tobacco & other drug use	Trialled with over 55s by Ryan [1]; limitations identified
BDEPQ – Benzodiazepine Dependence Questionnaire		✓		Benzodiazepine dependence	Yes
Screening questions for detecting benzodiazepine dependence		✓		Benzodiazepine dependence	No
SDS – Severity of Dependence Scale	✓	✓		Severity of psychological dependence on opioids	No
GDS-15 Geriatric Depression Scale			✓	Symptoms of depression	Yes
GAI – Geriatric Anxiety Inventory			✓	Severity of anxiety	Yes

Screening tools for alcohol problems

The following tools are available in the public domain.

ARPS – Alcohol-Related Problems Survey

The Alcohol-Related Problems Survey is a self-report instrument developed in the United States in response to the growing need for a screening measure for older adults. It is a preferred screen as it has been developed specifically for older adults and is more sensitive than the SMAST or the AUDIT (see below) [21]. It can be completed using pen and paper, and results are processed by computer.

There is an Australian version, the A-APRS, which has been adapted for Australian standard drink sizes and brand names of medications, and formally tested with a group of Australian older adults [22]. It can be administered using a tablet, laptop or desktop computer.

The ARPS identifies low risk, risky and harmful alcohol use. The A-ARPS has been used in the Older Wiser Lifestyles (OWL) program at Peninsula Health in Melbourne to screen for problems. The program provides both early interventions and treatment according to the level of risk that is identified in the screen.

The computerized version of the A-ARPS is online at www.wisedrinking.org. It takes 10 minutes or less to complete.

The original American version can be found at: http://www.public-health.uiowa.edu/icmha/outreach/documents/AlcoholUseSurveyforOlderAdults.pdf

SMAST-G – Short Michigan Alcoholism Screening Test – Geriatric Version

The Short Michigan Alcoholism Screening Test – Geriatric Version was the first short-form alcoholism screening instrument developed that was tailored to the needs of older adults. As a version for older adults, it is another preferred screening tool. It can identify dependence and harmful alcohol use but it does not identify hazardous alcohol use.

The test comprises ten questions, with a score of 2 or more 'yes' responses indicating an alcohol problem and the need for a comprehensive assessment. It is available at: http://smchealth.org/sites/default/files/docs/1309587945SHORTMICHIGANALCOHOLSCREENINGTEST.pdf

CAGE and CAGE-AID

The CAGE/CAGE-AID is included here because it is widely used [23] although it is less sensitive for older adults.

The CAGE acronym is derived from the four questions of the tool: Cut down, Annoyed, Guilty, and Eye-opener:

1. Have you ever felt you should **c**ut down on your drinking?
2. Have people **a**nnoyed you by criticizing your drinking?
3. Have you ever felt bad or **g**uilty about your drinking?
4. Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover (**e**ye-opener)?

The CAGE-AID is an adapted version to include drug use:

1. Have you ever felt you ought to cut down on your drinking or drug use?
2. Have people annoyed you by criticizing your drinking or drug use?
3. Have you felt bad or guilty about your drinking or drug use?
4. Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover (eye-opener)?

Two or more 'yes' answers is considered clinically significant for the general population. For older adults, a lower threshold of one positive answer is recommended because of their increased sensitivity to alcohol and other drugs.

AUDIT – Alcohol Use Disorders Identification Test

The Alcohol Use Disorders Identification Test was developed by the World Health Organization and is the gold standard screen for hazardous and harmful alcohol use. It is included here because of its widespread use, despite being less sensitive for older adults, again because of their increased sensitivity to alcohol and other drugs, as well as frequency of chronic health problems and interactions with medications.

The AUDIT has ten items. An abbreviated version, the AUDIT-C (consumption), uses the first three questions. Both the AUDIT and AUDIT-C have been found suitable for detecting hazardous alcohol use in drinkers aged over 65 [24]. It can be found at http://www.integration.samhsa.gov/images/res/tool_auditc.pdf.

Screening tool for alcohol and other drugs problems

ASSIST – Alcohol, Smoking and Substance Involvement Screening Test

The Alcohol, Smoking and Substance Involvement Screening Test is a brief screening questionnaire which was developed by the World Health Organization to screen for hazardous, harmful and dependent use of alcohol, tobacco and other psychoactive drugs in primary health care settings. Although it has been widely tested for validity and reliability, this has been with adults aged 18-45 and not within mental health settings. Suggestions for making it more useful for an older population who may also have mental health problems are contained in Appendix 1. These are based on an Australian study which investigated the usefulness of the ASSIST with adults with a mental illness aged over 55 [1].

The ASSIST provides a comprehensive AOD use screen and therefore has the clear advantage for screening older adults who may have used or are currently using a broader range of substances than earlier cohorts of older adults.

The ASSIST generates a risk score for each of ten different drugs or drug types which is linked to formal feedback and a brief intervention.

The ASSIST screening tool, brief intervention and self-help guidelines are available at: http://www.who.int/substance_abuse/activities/assist/en/.

Screens for drugs other than alcohol

When it comes to prescription medication abuse, there are few validated screening instruments for detecting problems. Two that we can use are the Benzodiazepine Dependence Questionnaire and the Severity of Dependence Scale.

Benzodiazepine screens

BDEPQ – Benzodiazepine Dependence Questionnaire

The Benzodiazepine Dependence Questionnaire is a preferred screen as it has been validated for use with older people. It measures dependence on benzodiazepines, and was designed to capture more than withdrawal symptoms in determining dependence. The questionnaire has 30 items and is located at the end of Manual for the Benzodiazepine Dependence Questionnaire, which is available at: https://ndarc.med.unsw.edu.au/sites/default/files/ndarc/resources/T.R%20033.pdf .

Screening questions for detecting benzodiazepine dependence

Also useful are the following two screening questions [25]:

- Over the past 12 months have you noticed any decrease in the effect of this medication (e.g. on sleep, sadness, anxiety)?
- Have you tried to stop taking this medication?

Unlike the BDEPQ, they have not been tested for validity and reliability and for this reason are less preferred.

SDS – Severity of Dependence Scale

The Severity of Dependence Scale provides a score indicating the severity of psychological dependence on opioids; the higher the score, the higher the level of dependence. Specific sensitivity for older adults has not been shown for the SDS.

Although the SDS was originally developed for assessing psychological dependence on heroin, studies have indicated that it is also suitable for assessing dependence on other illicit drugs, with different cut-off scores depending on the drug. It can be found at: http://nceta.flinders.edu.au/index.php/download_file/-/view/220/.

Mental health screening

Regular mental state examination is recommended, as is screening for other diseases related to ageing which can be confused with and complicate mental health and AOD use issues.

There are a number of mental health screens such as the MINI (Mini International Neuropsychiatric Interview). The MINI, although not developed for older adults, has a specific advantage in that it screens for a wide range of mental health concerns. An earlier version can be found here: http://www.medschool.lsuhsc.edu/psychiatry_residents/docs/MINI500.pdf.

Other screening tools include:

- the Brief Psychiatric Rating Scale http://www.public-health.uiowa.edu/icmha/outreach/documents/BPRS_expanded.PDF
- Mental Health Screening Form-III https://www.idph.state.ia.us/bh/common/pdf/substance_abuse/integrated_services/jackson_mentalhealth_screeningtool.pdf
- Kessler Psychological Distress Scale (K10) https://health.adelaide.edu.au/pros/docs/reports/br200214_k10.pdf

Although not necessarily standardised for older adults, these screens can provide indications for further assessment.

GDS-15 Geriatric Depression Scale

The Geriatric Depression Scale is a depression assessment tool specifically designed for older people. Because it is standardised for older adults it is a preferred screen.

There are four 'trigger' questions to alert a practitioner of the need to complete the 15-item GDS.

The GDS can be filled out by the client or administered by an interviewer. It comprises 15 questions about how the client has felt over the past week. A score above five suggests depression and indicates a more thorough clinical investigation. A score above ten almost always identifies depression.

The test is further described at http://www.health.vic.gov.au/agedcare/downloads/pdf/gds.pdf and is available at: https://www.healthcare.uiowa.edu/igec/tools/depression/GDS.pdf.

GAI – Geriatric Anxiety Inventory

The GAI is a short scale for measuring the severity of anxiety in older people. It has 20 items and can be self-administered or administered by a practitioner [26].

It is available at http://gai.net.au/.

3. Biomedical interventions

General factors to consider

Iatrogenic drug problems

Iatrogenic drug problems are the most common dual diagnosis feature in older people. Psychological and social interventions should be the primary interventions where possible, with medication playing a secondary role.

Close medical monitoring

Closer medical monitoring is appropriate because of the effects of comorbid physical and mental illness and possibly frailty as well.

Older adults are more likely than younger adults to drink alcohol along with taking prescribed medications, so possible interactions in particular should be monitored.

Effects of CNS depressants

CNS depressants in general, including alcohol, benzodiazepines and opioid analgesics, increase the risk of falls, cognitive impairment and incontinence, especially in the aged.

Alcohol

Withdrawal

Older people who are alcohol-dependent experience a more protracted and a more severe withdrawal than younger adults. For this reason they generally do not make suitable candidates for home-based withdrawal. Other reasons include a greater likelihood of medical comorbidity, poly-pharmacy, increased risk of delirium and social isolation.

Alcohol withdrawal symptoms:

Autonomic overactivity	Dyspepsia
Sweating	Delirium
Tachycardia	Cognitive and perceptual changes
Hypertension	
Insomnia	Anxiety
Tremor	Vivid dreams
Anorexia	Illusions
Nausea	Hallucinations
Vomiting	Fever

Medical management

- Fluid and electrolyte imbalances should be initially corrected
- Thiamine to prevent Wernicke-Korsakoff syndrome
- Parenteral thiamine should be given initially (e.g. 200mg IM BD for 3 days)
- Importance of multivitamins and general supportive care

Psychotropics should be prescribed with caution if hallucinations are present. Use of benzodiazepines should be sparing, because of increased sensitivity to adverse effects. Shorter-acting benzodiazepines such as oxazepam should be used in preference to diazepam because of poorer hepatic functioning, drug interactions and the increased risk of adverse effects.

Relapse prevention

Drugs used for alcohol relapse prevention can generally be prescribed for elderly patients as well:

- ***Acamprosate*** may be more safely used in the elderly, but may be relatively less effective compared with other medications. Lower doses are prescribed in those under 60kg and/or with renal impairment.
- ***Naltrexone*** may be used if hepatic impairment and the need for opioid analgesia are not issues. Liver function should be monitored after initiation.
- ***Disulfiram*** is more hazardous in the elderly because of the increased physical risks associated with the aldehyde reaction when alcohol is consumed. It may also precipitate a confusional state. It can be effective in highly motivated individuals when it is administered by another member of the person's household.

Benzodiazepines

Withdrawal

Withdrawal symptoms may be reduced because of slower clearance of the drug in older people.

Medical management

- Short-acting benzodiazepines should be changed over to a relatively longer acting benzodiazepine such as oxazepam. Oxazepam is preferred to diazepam because diazepam has an active metabolite and an extended half-life in older people.
- Dose reduction should generally be slower than the rate of 10 to 20% per week that is recommended for young adults

Relapse prevention

Relapse prevention focuses on addressing underlying anxiety and/or depressive disorders with appropriate pharmacological or psychological therapies. Advice on sleep hygiene, including the need for fewer hours of sleep in the aged, is

important where benzodiazepines have been used long term as a hypnotic.

Other psychological interventions that can be useful include cognitive behavioural therapy, mindfulness-based interventions and movement-based meditation (tai chi) [27].

Prescription drug misuse

Prescription drug misuse is the use of a medication other than as directed or indicated, including taking too little or too much of a drug, taking it too often, or taking it for too long, whether harm results or not.

4. Psychosocial interventions

The strong focus on biological factors and medications for control of symptoms of mental illness, especially psychotic disorders, sometimes overshadows important psychosocial aspects. We know that people with dual diagnosis often face a wide range of psychosocial issues, and further, that psychosocial factors are important in understanding the aetiology of dual diagnosis. We also know that psychosocial and socio-environmental aspects of AOD use are important to clients with mental illness.

Recent research in the AOD field describes how recovery is socially contagious. Opportunities for recovery can be grasped, and people around them can help them take advantage of such opportunities by increasing resources and supports during those windows of opportunity to 'catch' recovery [28].

Psychological treatment including psycho-education, counselling and motivational interviewing can be successful cognitive-behavioural approaches for reducing or stopping alcohol or other drug use. This includes teaching older adults the skills necessary to rebuild social support networks and use of self-management to overcome depression, grief and loneliness.

Principles of treatment

Integrated treatment

Providing integrated care is standard good practice for treating people with a dual diagnosis, because of the complexity and impacts on those experiencing these issues. This is no less the case with older adults with a dual diagnosis.

There are different models for providing integrated treatment:

- One practitioner might treat mental health and AOD use issues at the same time, if they are skilled in both areas
- More commonly, practitioners from separate services in each sector collaborate to provide integrated treatment

A 'No Wrong Door' policy means that whether a person presents to a mental health or an AOD service, their dual diagnosis will be addressed: either within the service or through working with practitioners in a service in the other sector.

Recovery and strength-based focus

A central tenet of treatment is a strengths focus, rather than a 'problem-based' focus. This means asking what people have done previously to reduce or stop their drug use, and assuming that they might want to talk about this. Further, it means assuming that recovery is possible, rather than thinking that older clients with a dual diagnosis don't want to or can't make change. A key feature of recovery is the value of participation and social connection for enhancing mental health.

It is part of the role of the practitioner to maintain a hopeful stance.

Older adults seek change. They have often had previous successful attempts which can form the basis for future change.

Other principles of treatment

Dual diagnosis work often needs:

- assertive outreach
- close monitoring to provide structure and social reinforcement
- stage-wise treatment to ensure appropriate timing of interventions
- an individualised approach: older adults are not all the same
- safe and protective living environment is fundamental to basic quality of life and to the success of treatment
- flexible clinicians and programs
- longitudinal perspective
- optimism

The change process

Communicating hope is part of recovery-oriented practice. Contrary to some assumptions, it is not too late for older adults to make changes. We can assume that they seek change, that change is possible and that they have made successful attempts at change in the past. A hopeful stance is good practice regardless of a client's age. It is particularly important for older ages because of stereotypes that say they are too old to change or that it doesn't matter if they change – and they may believe this themselves.

Stages of change

The change process is complex, heterogeneous and idiosyncratic, and awareness of an individual's stage of change can help to ensure that approaches are relevant [29]. It is important not to be too rigid in considering the use of this model. It is a fluid guide. Teesson and Proudfoot provide a summary of the evidence base for this model in dual diagnosis work [30].

There are six stages according to this model: pre-contemplation, contemplation, preparation, early action, late action and maintenance. Pre-contemplation does not mean nothing can be done. Lapses can occur throughout and usually mean, with the assistance of relapse prevention, a return to where the person was. Relapse indicates more substantial shifts back and requires work to regain motivation to change.

Stages of change [29]	
Pre-contemplation	'You may think it's an issue, but I don't, and even if I do, I don't want to do anything about it, so don't bug me.'
Contemplation	'I am willing to discuss it, think about it, and consider whether to change, but I have no interest in changing, at least not now.'
Preparation	'I am ready to start changing, but I haven't started, and need some help to begin.'
Early action	'I have already begun to make changes and need some help to continue, but I am not committed to maintenance.'
Late action	'I am working toward maintenance but haven't got there, and need some help to get there.'
Maintenance	'I am stable and I am trying to stay that way as life throws challenges at me.'

Motivational interviewing

Motivational interviewing (MI) is an approach for facilitating movement through the stages of change, and is worth learning if not already done. Using the stages of change model and enhancing motivations towards change regarding AOD use and insight into mental illness is effective in treating dual diagnosis.

The following outlines the spirit of motivational interviewing:

- Motivation to change is elicited from the client, and not imposed
- It is the client's task, not the counsellor's, to articulate and resolve ambivalence
- Direct persuasion is not an effective method for resolving ambivalence
- The counselling style is generally a quiet and eliciting one
- The counsellor is directive in helping the client to examine and resolve ambivalence (which makes MI especially suitable for those in the contemplation stage)
- Readiness to change is a product of interpersonal interaction and not a trait
- The therapeutic relationship is more like a partnership than an expert and client relationship

Motivational interviewing is a process to move people towards appropriate interventions rather than an end in itself.

Variations for older adults with a dual diagnosis

Consider further nuancing the stages of change model and motivational interviewing when working with older adults with dual diagnosis:

- What might appear as pre-contemplation could reflect anything from 'happy use' to having 'given up hope'
- We know that once older adults enter treatment, they can do well, so more overt encouragement towards 'action' might be helpful for this group
- The severity of alcohol dependence has a direct positive effect on motivation to change. Therefore, establishing if dependency exists, and clearly communicating this to older adults, could enhance movements towards change.
- Keep in mind a strengths approach and an emphasis on hope and welcome for older people with a dual diagnosis
- Ask what substances they have never started using, or had started and previously stopped, and why. We can assume that older clients might want to talk about this and it can provide a strengths-based lever for considering current AOD use [1]
- Put a greater emphasis on overt, pro-active encouragement and reminders of unpleasantness and risks for those who are at a pre-contemplative stage [1]

Reasons for Use (RFU)

Investigating the reasons for use is central to understanding the subjective perspective of people with dual diagnosis, so engaging older adults in conversation about their reasons for use can be an important basis on which treatment can proceed. It can provide an understanding of how they see the association between mental health and AOD use concerns and what maintains and assists recovery from dual diagnosis. Research indicates that a better understanding of why people with mental illness use alcohol and other drugs can improve the effectiveness of treatment [31, 32]

Older adults' reasons for use

A RFU scale for older adults with mental illness has been developed [1] and is in the process of further trialling. It can be used to enhance a conversation into reasons for use in an older dual diagnosis age – simply by asking the person if they agree or otherwise with the reasons offered.

Contact Kathleen Ryan at NEXUS for further information.

Overlap between reasons for use and reasons for change

Many of the motivating factors behind AOD use also contain the seeds of change; they represent two sides of the same coin. For example, the main reason to use may be temporary relief from distress, with the key reason to change being that relief from distress is only temporary. (In one study, reasons for AOD use were found not to be related to 'self-medicating' of mental illness symptoms and/or side effects. Rather, the reasons for use were most commonly described as providing relief from substantial distress [1]).

Therefore:

- use information about RFU to start a conversation about the client's AOD use, by simply asking 'do you agree with this reason…?', 'Do you think it accurately reflects your use of….?'
- Ask: 'how is that (specific reason) working for you?', 'Is there any down side to that reason for use?'

Additional interventions have been developed, for further trial, by NEXUS. Contact Kathleen Ryan, NEXUS, for more information

Brief interventions

Brief interventions, as a follow-up to screening, are commonly used in primary care settings with adults with non-dependent but unhealthy AOD use. Studies suggest that brief interventions are effective with older people, with one or more counselling sessions including assessment, motivational work, patient education and feedback, contracting (for example to keep a drink diary), use of written materials, and setting goals and incentives to reduce use.

Brief interventions are aimed at the person who has not openly reported a drug or alcohol problem, rather than someone who has actively sought help for a drug or alcohol problem. Therefore there are two main elements of a brief intervention; identifying the problem via screening, and the counselling intervention itself.

The components of brief interventions can be understood in terms of the FRAMES acronym:

Components of a brief intervention	
FEEDBACK	'So, you say your difficulty attending your appointments on time may be related to alcohol. What could you do about that?'
RESPONSIBILITY	'Well, only you can make the decision to stop drinking for the next two weeks.'
ADVICE	'Yes, I recommend you stop drinking for two weeks, to see if that makes a difference.'
MENU OF OPTIONS	'If this turns out to be too hard, we can consider other options such as AA or referral to the specialist team.'
EMPATHY	'I know this will be hard for you because you feel alcohol helps you relax, and I'm concerned about the amount of stress you have.'
SELF-EFFICACY	'Considering how difficult you find this, I'm impressed by your willingness to consider a change.'

Older adults can be unaware of what constitutes low-risk drinking, so an important part of advice-giving is to assist these clients to understand what constitutes a standard drink and low-risk drinking. Draw out older adults about the amount of alcohol they drink. One way to do this is to give them a glass and let them pour to show you the amount. Charts of Australian standard drinks can be downloaded from here: https://www.nhmrc.gov.au/health-topics/alcohol-guidelines.

Similarly, appropriate psycho-social educational material needs to be routinely provided, especially considering that older adults can be willing to change if risks are outlined. Consider if large print versions are required.

It is important to acknowledge and work through stressful life events and distress at the individual's pace.

Older adults' reasons for use are often related to experiencing distress. Consider what needs they are trying to meet by using alcohol, and how else their needs might be fulfilled. This also might take time to untangle if the older person is not inclined towards introspection.

Harm reduction

Within drug policy, harm reduction is a strategy that comes under the umbrella of harm minimisation. Harm minimisation recognises that drug use, both licit and illicit, is an inevitable part of society, and aims to reduce the harmful effects of alcohol and other drugs on the user and the community as a whole. It has underpinned state and federal policy since 1985.

On the practice level, harm reduction describes a way of working with people who use alcohol and other drugs, where the aim is to reduce the adverse consequences of continued drug use. It is based on the understanding that at any given time, some drug users are not interested in changing – reducing or stopping – their AOD use.

This makes harm reduction an appropriate approach for working with pre-contemplators. The focus of harm reduction work is the harms associated with use, rather than use *per se*.

A harm reduction approach is not inconsistent with a goal of abstinence. Rather, it concentrates on short-term, practical goal-setting rather than emphasising idealistic or long-term goals. Essentially it is about preventing or reducing adverse consequences of AOD use even while use continues, at least in the short term.

Harm reduction approach – older adults with a dual diagnosis

Although many older people with a dual diagnosis want to and can change their AOD use, research also shows that some might not be able to, or might not want to gain insight into their AOD use or to change it. With these clients, harm reduction is important. Further, exploring the impact of AOD use on physical and mental health within a discussion about reducing their harm can be a strong motivator towards change [1].

A range of harms are associated with different types and patterns of AOD use and a range of approaches can be used to respond to these risks. Consider harm broadly in terms of AOD acquisition, use, withdrawal, recovery within a bio-psych-social framework. See Appendix 2 for grids that can be used as an aid to considering harm broadly.

There are no specific guidelines for safe alcohol consumption for older people. The *Australian Guidelines to Reduce Health Risks from Drinking Alcohol* states:

1) For healthy men and women, drinking no more than two standard drinks on any day reduces the lifetime risk of harm from alcohol-related disease or injury.
2) For healthy men and women, drinking no more than four standard drinks on a single occasion reduces the risk of alcohol-related injury arising from that occasion.

It also states, "… 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 level of drinking for their health" [4].

The National Institute on Alcohol Abuse and Alcoholism (NIAAA) in America also recommends that "Abstinence should be advised to individuals who … take prescriptions or over-the-counter medications that may interact with alcohol, [and who] have a physical or mental health condition that may be exacerbated by alcohol" [37]. These situations are more likely to apply to older adults.

Relapse prevention

Once an older person with an AOD use problem has made some changes, there is still work to be done to move into the maintenance phase, and most will need further support. They can experience things like insomnia, vivid or troubling dreams, mood swings, craving for sweet food, poor appetite, and flashbacks. They might also display a naïve optimism [18].

Relapse prevention work aims to avert return to dependent use, and in the event of a lapse, preventing it from becoming a full relapse. It involves identifying risk situations, thoughts and emotions, and developing strategies for dealing with them when they arise. Central to this is help with managing cravings.

Psychotherapy

Older adults can vary in their response to psychotherapy and other counselling. Some regard counselling techniques as formulaic or impersonal, while others, especially if treatment naïve, find the idea intimidating. Alternatively, older people can respond well to creative therapies such as drama and art therapy, although they can be put off if such initiatives are introduced too forcefully.

AOD use counselling – approaches for older adults

While general counselling principles apply when working with older people with a dual diagnosis, there are also some specific considerations to bear in mind.

Individual temperament

Consider individual temperament and the role AOD use has in managing temperament. For example some older adults experience problems processing feelings (which could reflect the era they grew up in), such as a tendency to globalise current mood, or else being very driven and finding it difficult to switch off.

Maintain hope

The counsellor has the task of 'holding the hope' for the client. This is a core task and follows from assuming from the start that change is possible. This is especially important for older clients because of the common assumption that they do not want to or are unable to implement change.

Social support

Social isolation is a bigger risk for older adults than for younger people.

Social supports need to have spiritual as well as physiological, psychological, social-environmental components. Changes in spirituality (finding meaning in life) and values are part of the normal ageing process, as older adults come to terms with the ageing process and the fact of their own

mortality. This can involve shifts in values attached to relationships, success and failure, and material possessions.

Individualised treatment might include:

- providing culturally safe support where required to build confidence
- age-specific programs
- appropriate settings (physically accessible services, outreach programs)
- use of group therapies
- self-help groups that emphasise social support

Self-help groups / peer-based intervention

Participating in self-help groups can improve older people's psychological and physical health, alleviating symptoms of depression, physical conditions and adjustment to a caring role and bereavement [33]. Research also suggests that (as do many people) older people fare better if they are in groups of their peers, and might prefer smaller groups as being less intimidating [34].

Specialist AOD services for older adults

Dependent drinkers usually require specialist treatment, including inpatient withdrawal and residential programs. Self-help groups such as Alcoholics Anonymous and SMART Recovery may also play an important role.

Older people who are dependent on other drugs, including prescription medication, can benefit from community based programs for older adults.

Currently, there are few older people in drug treatment programs, so there is limited information, along with few specialists in this area.

Older Wiser Lifestyles (OWL) program

The OWL program, a Melbourne based specialist AOD service for adults aged 60 and over, provides prevention activity, and early intervention or treatment (as indicated by the A-APRS screen).

The early intervention involves individual feedback, education (about how alcohol and other drugs interact with a client's medications and state of health), and motivational interviewing (for contemplators) or harm reduction education (for pre-contemplators).

Treatment, for those whose drinking is at harmful levels, includes long-term counselling, outreach and support groups for education and peer support [35].

Mental health services for older adults

In recognition of the different mental health needs of older adults compared with younger adults, specialised aged persons psychiatric services have been established across Australia.

In older adults the qualitative features of some disorders such as depression can be distinct from those in younger adults, resulting in some underreporting of mental illness symptoms. The incidence of cognitive disorders is significantly greater among older adults.

5. For carers

Caring for an older person with an AOD problem and mental health problems can be extremely challenging. At the same time, carers are central to the success of treatment for their loved one who is experiencing these issues.

Research into the role of family, friends and significant others in treatment and recovery is well documented, but little is known about the carer support role for the older person with a dual diagnosis. While we know that the involvement of close family and friends in treatment has a positive effect overall, caring for an older person with comorbid mental health and problematic AOD use brings about increased complexity and multiple challenges.

Carers of older persons with a dual diagnosis are often the older person's adult children. This can mean a role reversal of the caring relationship as the adult child becomes the carer of their parent. Adjusting to this role change may take some time, depending on factors such as the historical dynamics in the relationship and the length and severity of the decline or illness in the older person.

Carers, no matter what age or whom they are caring for, require support for what can be at times a demanding and testing role. Carers are at higher risk of mental and physical health problems because of their caring role.

What does a carer do?

The caring role can be taken on by a variety of people involved in the care recipient's life, and the role itself can vary considerably in terms of time spent in the caring role and the complexity of the role. It may not be a term that people identify with, as they have assumed the caring role by virtue of being a close family member.

The types of support provided includes:

- friendship
- advocacy
- financial, emotional and practical support
- monitoring symptoms and facilitation of access to treatment
- encouragement to engage in recovery activities.

In terms of time, the caring role might:

- be a full time role
- be unpredictable and vary in intensity at times
- only take up a very small amount of the carer's time or effort
- be difficult to judge/separate from one's other daily commitments

Services can vary in who they define as 'carer' and this might affect eligibility, for example, for respite options. A primary carer is the person who provides most of the support. Within mental health services, the primary carer has a right to certain consumer information relating to their caring role for a person with a mental illness.

Carer involvement in treatment

Family members and carers are central to the recovery of a person with a dual diagnosis. It is well accepted that carer involvement is needed in treatment decisions and planning.

Carers may need information relating to:

- the mental health diagnosis, signs and symptoms and where they can access further information about it
- options for treatment
- information about medication
- contact numbers for the support services that may be needed
- advice about what recovery may look like

On their side, it is important for health professionals to consider:

- how the family/carers can be involved in discussions concerning treatment
- how carers are advised on the day-to-day management of the person they provide support to
- referral to local carer support agencies / groups / resources
- the support needs of the carer and referral pathways to address these
- the viability of the carer role in the future (carer may be frail/aged or unsure if they can continue to provide adequate support)

Working with the mental health system

Information, confidentiality and consent

Families and carers need to know about their rights under the relevant legislation. Victoria's *Mental Health Act 2014* places individuals and carers at the centre of mental health treatment and care. The Act recognises the important role of families and carers in supporting their family members and promotes joint decision-making and strong communication between practitioners, patients and their families and carers [35]:

> *The Act seeks to ensure carers will receive the information they need to provide care or to determine the nature and scope of care to be provided to a patient and to make the necessary arrangements in preparation for their caring role, or to provide care to the patient. In making a decision to provide information in these circumstances, the person providing the information must have regard to the patient's views and preferences about the disclosure, including any preferences expressed in an advance statement.*

Information disclosed in these circumstances may include about the treatment and management of mental illness, how to respond to disturbing behaviours, how to access practical assistance and generally assisting carers to better support the person with mental illness [35].

Respite options

Respite provides short term and time limited breaks for families/carers of people with a mental illness, on a planned or emergency basis, to support and maintain the primary care giving relationship while providing a positive experience for the care recipient.

Different types of respite are available according to the needs of individual families and the services available. Services include:

- unplanned respite in response to a crisis or emergency situation.
- regular respite occurring at a regular time each week or at regular intervals
- arranged respite on an 'as needed basis'
- variable time frames lasting a few hours, overnight or several days
- a choice of location including in own home, in the home of another friend/ family member, community aged care setting, a planned outing or activity or activity group.

How best to support a person with a dual diagnosis

Some strategies have been identified as more helpful than others. Listed below are some tips for providing support to the care recipient, whilst also considering the needs of the carer.

What works

Working together with others

- Family being involved in treatment and recovery conversations with the treating team
- Carers, family and health professionals working together towards a shared vision
- Coming to an agreement about drug use within the home or other situations
- Agreeing that if the person cannot achieve abstinence, a reduction in alcohol or other drug use can be an appropriate goal.

In the direct carer role

- Addressing the care recipient's feelings of guilt or shame associated with AOD use
- Setting clear boundaries around behaviour and limits on unacceptable behaviour
- Encouraging small achievements, fostering hope
- Identifying when drug use is likely to occur; i.e., 'trigger situations'
- Encouraging independence with small steps at a time
- Above all, if something is not working, rather than continuing with it, consulting with others and trying something new.

In communication

- Using 'I' statements (for example, 'I feel stressed when you ask me for money', as opposed to 'you are always asking me for money'). 'I' statements are less blaming and conflictual than statements that start with 'you' or 'they'.
- Setting clear boundaries, written or spoken
- Maintaining respect and expressing concern, as opposed to reacting in anger
- Not trying to communicate with an intoxicated person
- Being involved in counselling and understanding the person's experience of AOD use and mental ill health.

For the carer

- Supporting and caring, but not taking responsibility for the care recipient's actions
- Taking time out of the caring role
- Building resilience and seeking out education and support
- Speaking with the case manager, doctor, AOD worker or another carer
- Contacting carer support services
- Trying to gain some understanding of why the person uses drugs
- Staying educated on the subject; learning about the 'stages of change' and the effects of the drugs being used.

In particular situations or crises, you may need to act quickly to protect yourself and the other person as safety always comes first.

And what doesn't work:

- Threatening, criticising, yelling at the person
- Providing cash often or on demand
- Demanding that drug use stop immediately
- Searching personal possessions
- Demanding urine tests
- Relenting on set boundaries.

Carer self-care

Recognising emotional responses to stress

Family members may experience significant stress when caring for a person with dual diagnosis. Feelings often reported by carers include anger, grief, loss, embarrassment, shame, hopelessness, fear for the future, anguish, bewilderment and an overwhelming sense of responsibility.

Feelings of guilt often emerge when a loved one is caring for someone with a mental illness. It is important to remember that mental illness is an illness and that it can happen to anyone from all walks of life and culture. Guilt and feelings that are associated with the caring role are individual and so are the ways of dealing with them. However, ignoring them can often result in physical and emotional burnout. Over time, if these feelings are not addressed they can become worse or bring about other symptoms such as:

- worry
- sleeping problems
- confusion/difficulty making decisions
- low mood or depression
- weight loss or gain
- violent outbursts
- loss of confidence and
- social isolation.

Loss and grief

Carers of people with a mental illness and dual diagnosis experience grief and loss but it is often overlooked and goes unrecognized. Grief is the emotional pain that comes about as a result of a loss or a number of losses. It is often overlooked because the losses are less visible than they would be with a physical illness or disability. It is one of the strongest emotions which often causes carers the greatest stress. Recognizing your grief and talking to someone about how you are feeling can help.

Being proactive

What we know	Ask yourself	Where to get more information
Knowledge is power	Am I educated about my loved one's condition?	If you have questions about the nature of the illness, seek more information from the treating team or from the GP. Ask for written information that you can take home and read. Write down any further questions you may have.
Violence and intimidation are often associated with money for drugs or alcohol.	Is my home as safe as I need it to be? Have I thought about ways to stay safe?	Safety is an important consideration and the ideal home provides safety and makes caring tasks easier. Some carers have to consider safety issues related to behaviours of the people they care for. Refer to the Safety at Home factsheet on the Carers Victoria website.
Advocating within the system for your loved one takes energy and strength.	Am I working together with the treatment team to ensure that the person I am caring for gets all they help they need?	Don't be afraid to keep asking for help where you think it is needed. You will need other health professionals to support you both along the way.
Having insight regarding the other person's illness is not easy and takes time.	Do I understand that I can't make the changes for them?	Linking in with others who know about mental illness and AOD use will help to gain a realistic idea of what recovery looks like and the time it may take.
Suicide and the threat of suicide can be a behaviour of people with dual diagnosis.	Can I recognize symptoms and know where to seek treatment and support?	If someone is in immediate danger, or you are concerned about safety in any way, call 000. For immediate and free telephone assistance relating to suicidal thoughts, contact SuicideLine on 1300 651 251 (Victorian 24 hour helpline) or Lifeline.Ensure that the treating team and GP are aware of any suicidal thoughts, past or present.
Relapse may be higher for someone with a dual diagnosis but it is also part of the cycle of change. It is often very difficult for family/carers to watch a relapse.	In difficult times, do I allow myself extra time to care for my own wellbeing?	The impact of caring for someone should not be overlooked—don't hesitate to put your hand up and ask for help, stay healthy, keep safe, look after your own mental health, seek support and develop your own strategies to keep well.

Taking care of yourself

Caring has many demands on your physical and emotional health. Looking after yourself will assist you in your caring role but to keep your own health intact. Things to ask yourself:

- Do I share the responsibilities of my caring role?
- Am I getting enough breaks?
- Have I made regular times to relax?
- Do I get enough sleep?
- Am I trying to allocate regular exercise time?
- Do I get healthy regular meals?
- Have I got someone I feel comfortable and trust to talk about how I'm feeling?
- Do I foster friendships?
- Have I continued to do the things I enjoy?
- Would seeking professional help be useful?
- Would attending family support groups be useful?

Continue doing things that you enjoy in life:

- Visit family and friends
- Spend time with pets
- Exercise
- Spend time relaxing
- Arrange good family time together
- Make a list of enjoyable family activities
- Maintain respect for family member
- Work in the garden
- Practise your religion

Allow yourself some 'me' time

Whatever works for you – do it!

Appendix 1. Suggestions for using the ASSIST with older adults who have a mental illness

As described in Section 2, the ASSIST (Alcohol, Smoking and Substance Involvement Screening Test) has the advantage of screening for a broad range of substances. It has also been widely tested for reliability and validity, but has not been specifically calibrated for an older population with mental illness.

A 2012 Australian study examined the usefulness of the ASSIST for adults aged 55 years and older [1]. Suggestions for adapting the ASSIST for use with this population are offered.

Question 3 asks about frequency of 'a strong desire or urge to use'. Some participants in Ryan's study did not quite understand 'strong desire or urge' and related better to prompts such as 'Do you think a lot about drug/alcohol use?' or 'Do you feel you want to use drugs/alcohol a lot?' Some participants said they needed to use to stay awake through the day, so adding prompts such as 'Do you feel you need alcohol or other drugs to keep you awake or keep you going through the day?' and 'Do you feel you are addicted?' may be helpful.

Question 5 required further prompting as participants did not readily identify with failing to do what was normally expected of her/him because of her/his use of a particular substances/s. Nevertheless some related better to an additional prompt regarding having missed appointments with practitioners.

Also, some related better to question 6 when asked if a practitioner had ever expressed concern, rather than a family of friend having ever expressed concern.

Mental illness

The risk estimation could be revised for psychoactive drugs like cannabis, amphetamines or cocaine as the Feedback Report Card for Patients specifies that 'regular' use is associated with risks but we know that for some people with a mental illness, intermittent and low dose use can produce risks. A person might use infrequently, but because of super-sensitivity even this infrequent use can lead to psychosis. Therefore it might be more appropriate when using the ASSIST with people with a mental illness (in particular psychotic illnesses), to add an 'ever used' score of 3 to the risk score for each drug ever used.

Contact Kathleen Ryan, NEXUS, for more information on utilising this screen with the incorporation of additional prompts.

Appendix 2: Identifying drug-related harm and strategies to reduce harm

Identifying drug-related harm

Identify the drug-related harm, or the risk of drug-related harm, at each stage in the drug use cycle and for each of the domains of harm at each stage.

Domain of harm	Acquisition	Administration	Effects of the drug	Recovery and withdrawal
Physical				
Psychological				
Social				

Strategies for reducing drug-related harm

Think of strategies, other than total abstinence, which could be used to reduce drug-related harm, or reduce the risk of drug-related harm, at each stage in the drug use cycle and for each of the domains of harm at each stage.

Domain of harm	Acquisition	Administration	Effects of the drug	Recovery and withdrawal
Physical				
Psychological				
Social				

Resources and General References

Resources

Alcohol and Health in Older People
http://www.alcoholandolderhealth.co.uk/

Carers Victoria. Freecall 1800 242 636: Carer advisory line from anywhere within Victoria (freecall from local phones, mobile calls at mobile rates) http://www.carersvictoria.org.au/

SANE Australia Aged Care Project
http://www.sane.org/growing-older-staying-well, SANE's Guide to Ageing Well
https://www.sane.org/sane-guide-to-ageing-well

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