

PREVENTING AND REDUCING ALCOHOL AND OTHER DRUG-RELATED HARM AMONG OLDER PEOPLE

*A practical guide for
health and welfare professionals*



Roger Nicholas

Ann Roche

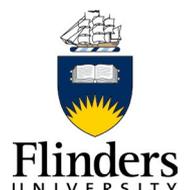
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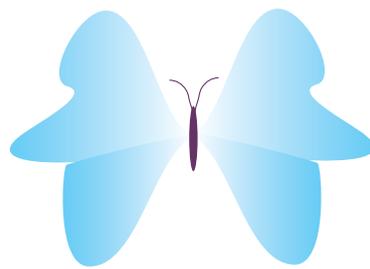
Katherine Walsh



OWL
Older Wiser
Lifestyles



Ageing is not lost youth
but a new stage of
opportunity and strength



Betty Friedan

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- Victorian Department of Health and Human Services
- Australian Government Department of Health
- St. John of God Health Care.

The Older Wiser Lifestyles (OWL) Program, Peninsula Health, Victoria

Older Wiser Lifestyles (OWL) is Australia's first older adult age-specific alcohol and other drug (AOD) service. It was established by Peninsula Health in 2009 following the identification of a service gap. OWL aims to elevate the issues in regard to AOD use among older adults and provide leadership in the development and delivery of evidence-based models of care.

Peninsula Health commissioned the National Centre for Education and Training on Addiction (NCETA) to develop this resource.

NCETA

The National Centre for Education and Training on Addiction (NCETA) is an internationally recognised research centre that works as a catalyst for change in the alcohol and other drugs field. Our mission is to advance the capacity of organisations and workers to respond to alcohol- and drug-related problems. Our core business is the promotion of workforce development (WFD) principles, research and evaluation of effective practices; investigating the prevalence and effects of alcohol and other drug use in society; and the development and evaluation of prevention and intervention programs, policy and resources for workplaces and organisations. NCETA is based at Flinders University and is a collaboration between the University and the Australian Government Department of Health.

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For further information about NCETA's work on alcohol and other drugs and older people visit our website www.nceta.flinders.edu.au.

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FOREWORD

This guide was developed to assist specialist and generalist clinicians to assess and respond to the needs of older people experiencing, or at risk of experiencing, alcohol- and other drug-(AOD) related harm. Longer life expectancy, more people living longer, and different expectations of current and future generations of older people will increase service delivery demands.

This resource is a practical guide for:

- *Health workers*
- *Service providers*
- *Policy makers.*

Alcohol and other drug use patterns and problems among older Australians have been under-researched and are not well understood. It is an emerging area of concern that requires:

- *Greater resources*
- *Improved understanding*
- *Changes in health service provision and delivery.*

The term ‘older people’ can be defined in various ways. Here, we generally refer to people aged 55 years and above. For Aboriginal and Torres Strait Islanders, services may also need to target people younger than 55 years.

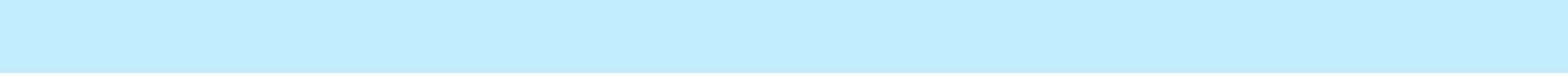
The term ‘older people’ should not be interpreted to mean a single undifferentiated group. Sensitive responses are required to address the needs of the diverse population groups that fall under the broad umbrella heading of ‘older people’.

The unique requirements of different age groups need to be addressed. Those aged 55-65, 66-80 and 80+ may have had diverse life experiences and be at very different places in their life’s journey. Similarly, those from different cultural backgrounds may have specific needs, as will Aboriginal and Torres Strait Islanders.

The substances addressed in this guide fall into four broad categories:

1. *Alcohol*
2. *Illicit drugs (including cannabis, heroin, amphetamines)*
3. *Medicines used in opioid substitution therapy (OST)*
4. *Prescription and over the counter (OTC) drugs.*

Each drug group is addressed separately, followed by generic principles applicable across all AOD issues. Finally, this resource contains details of the Older Wiser Lifestyles (OWL) Program as an example of an intervention and response approach.



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PART 1: INTRODUCTION

Summary

Alcohol- and other drug-(AOD) related harms among older Australians are increasing.

Australia's population is ageing and the current cohort of 'younger older' Australians (i.e., the 'baby boomers' born between 1946 and 1964) use alcohol and other drugs at higher rates than their predecessors. Consequently, a larger number of older people will require treatment for substance use problems in the future.

Problematic use of alcohol and illicit drugs is increasing among older Australians, as is the use of prescribed psychoactive drugs. In addition, opioid substitution clients are ageing.

Older harmful substance users can be categorised as:

- Maintainers (those whose previously unproblematic use has become harmful)
- Reactors (late onset users)
- Survivors (early onset users).

Older Australians are highly heterogeneous and require a range of prevention and treatment programs that reflect this diversity.

Older people use alcohol and other drugs for similar reasons to the rest of the population, but have physiological, psychological and social characteristics that make them more vulnerable to problematic use.

Many older people with substance use problems have physical and mental health comorbidities and are vulnerable to interactions between prescribed and non-prescribed substances.

Older Australians particularly at risk of AOD-related harm include:

- Aboriginal and Torres Strait Islanders
- Culturally and linguistically diverse people
- Lesbian, gay, bisexual, transgender, queer, and intersex people
- Women
- Injecting drug users.

1.1 Epidemiology

1.1.1 Demographics

Australia’s population is ageing, primarily as a result of sustained low fertility and increasing life expectancy. The proportion of the population aged ≥65 years is projected to increase from 14% in 2014 to 18-20% in 2032 (see Figure 1).

Current projections suggest that there will be 40,000 people aged over 100 years by 2054-55. This is:

- Almost nine times the number in 2014-15
- Well over 300 times the number in 1974-75 (The Treasury, 2015).

In the next 40 years, there will also be substantial reductions in the number of people aged 15 to 64 relative to the number of people aged 65 and over (see Figure 2). By 2054-55, more than 22% of the Australian population will be aged ≥65 years, compared to 15% today (The Treasury, 2015).

Current demographic trends have major implications for the future provision of services to older people with alcohol and other drug problems.

Baby boomers use alcohol and drugs at higher rates than previous generations, and greater numbers of older people will experience harm as a result (Han, Gfroerer, & Colliver, 2009; Hunter, Lubman, & Barratt, 2011). Even if the proportion of older adults with AOD problems remained constant, the increased size of this population will produce a dramatic growth in the absolute number of older people with AOD problems (Dowling, Weiss, & Condon, 2008).

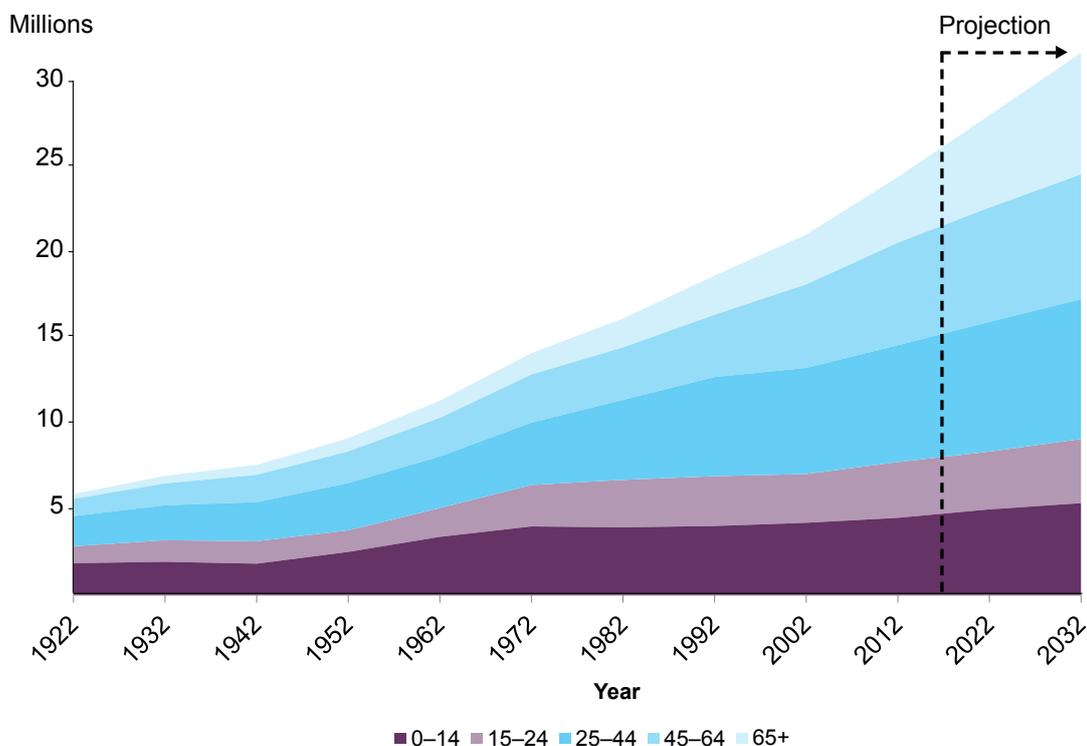
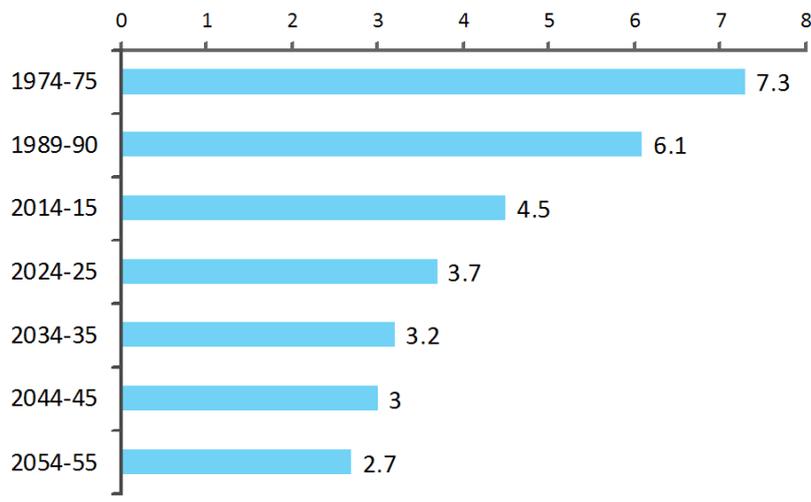


Figure 1: Historical and projected Australian population, 1922–2032
Source: Australian Institute of Health and Welfare, 2013.



In the future greater proportions of Australia's population will be aged over 65 years.

There will also be fewer younger people available to care for older adults.

Figure 2: Number of people aged 15 to 64 relative to the number of people aged 65 and over
 Source: The Treasury, 2015.

1.1.2 Patterns of use

1.1.2.1 Alcohol

Alcohol is the most commonly used drug and causes most AOD-related problems and harms among older people. Between 2001 and 2013, among 60-69 year olds:

- Short-term risky drinkers¹ increased by 31% (12.4% vs 16.3%)
- Lifetime risky drinkers² increased by 20% (15.5% vs 18.6%) (see Figure 3).

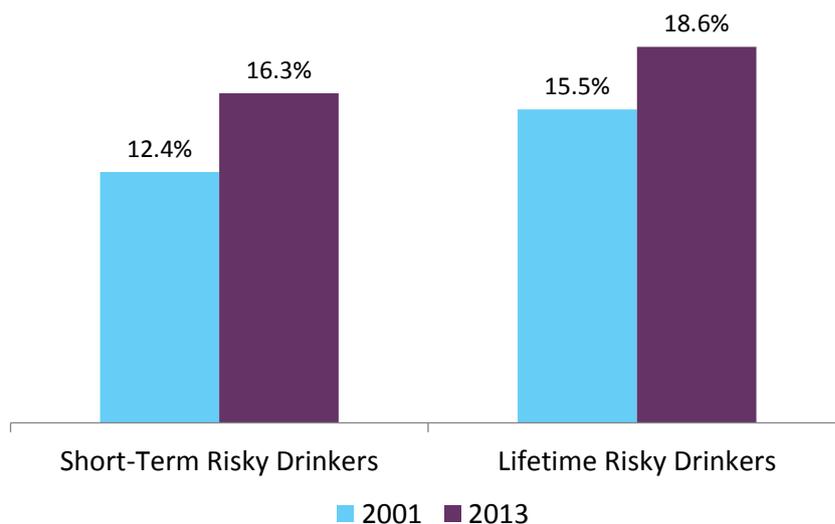


Figure 3: Percentage of Australians aged 60-69 who were short-term and lifetime risky drinkers 2001 and 2013 – National Drug Strategy Household Survey data
 Source: Australian Institute of Health and Welfare, 2014a.

1 Short-term risky drinking is defined by NHMRC as the consumption of more than 4 standard drinks on a single occasion at least once per month.

2 Lifetime risky drinking is defined by NHMRC as the consumption of more than 2 standard drinks per day on average.

The data in Figure 3 may be conservative due to under-reporting. Older people also pour alcoholic drinks that are 16-32% larger than a standard drink (10 grams of alcohol). Older men have been shown to over-pour spirits by 58% (Wilkinson, Allsop, & Chikritzhs, 2011).

Older people also comprise the largest proportion of the population who drink on a daily basis (see Figure 4).

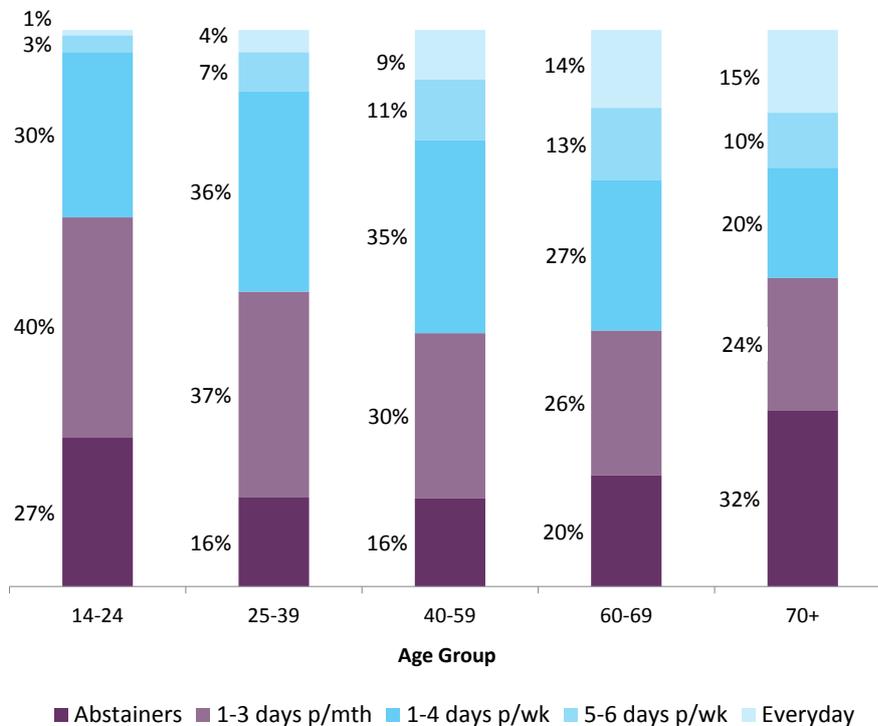


Figure 4: Frequency of Australian alcohol consumption by age group 2013

Source: National Centre for Education and Training on Addiction (2015a). Secondary analysis of National Drug Strategy Household Survey data (Australian Institute of Health and Welfare, 2014a).

In sufficient quantities, daily drinking can:

- Impair functionality and hand-eye coordination
- Cause sleeping difficulties
- Elevate cancer risk (especially bowel and breast cancer)
- Contribute to economic hardship and weight gain.

Older Australians (especially women) living in retirement villages appear to drink more frequently than those living in private homes, but do not necessarily consume larger quantities of alcohol. This may stem from:

- Greater levels of social engagement in retirement villages, facilitating opportunities to drink alcohol
- No need to drive home after social activities
- Positive normative drinking practices within retirement village communities (Wilkinson, Dare, Waters, Allsop, & McHale, 2012).

The type of alcohol people drink also changes over the life span. Older people consume proportionally more cask, bottled and fortified wine, and low strength beer (National Centre for Education and Training on Addiction, 2015a).

1.1.2.2 Other drugs (illicits)

In previous generations, it was rare for an older person to use illicit drugs. Today, a substantial proportion of older people have previously used some form of illicit drug and some have continued to do so as they have aged (Beynon, 2009; Han et al., 2009; Wu & Blazer, 2011). Recent illicit drug use (i.e., last 12 months) among older Australians has also increased over the past decade, in contrast to other age groups where drug use has declined (see Figure 5).

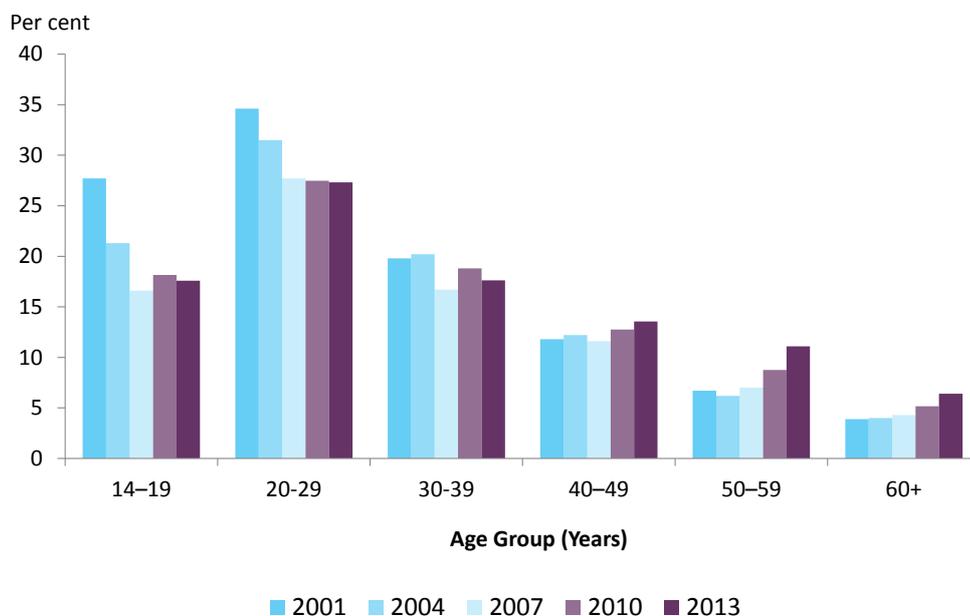


Figure 5: Recent illicit use of any drug, people aged 14 or older, by age, 2001 to 2013

Source: National Centre for Education and Training on Addiction (2015a). Secondary analysis of National Drug Strategy Household Survey data (Australian Institute of Health and Welfare, 2014a).

Cannabis is the illicit drug most frequently used by older Australians, with 7.3% of 50-59 year olds and 1.2% of 60+ year olds having used it in the last 12 months (Australian Institute of Health and Welfare, 2014a).

1.1.2.3 Opioid substitution therapy (OST)

Australians receiving OST are ageing. From 2006 to 2013 the proportion of OST clients aged <30 years more than halved (from 28% to 11%), while those aged ≥50 more than doubled (from 8% to 19%) (see Figure 6). Contributory factors include:

- Some clients remaining in treatment for several decades
- Pharmacotherapy treatment reducing the risk of premature death
- More clients seeking treatment for the first time at an older age (Australian Institute of Health and Welfare, 2014b).

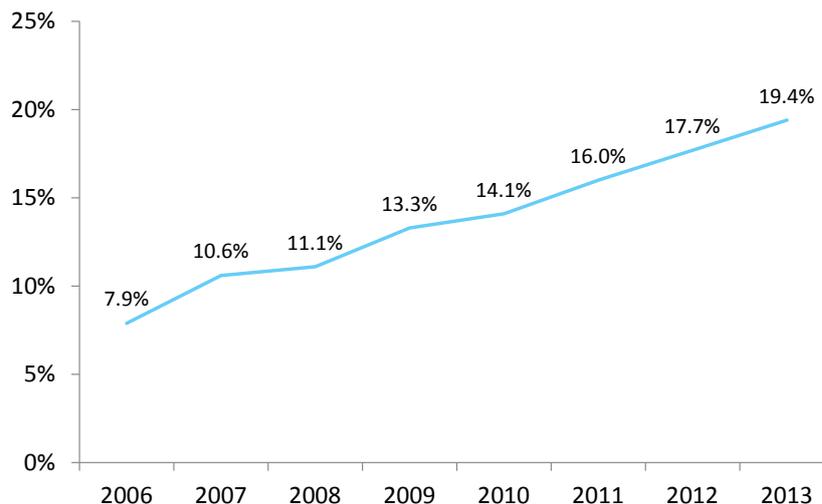


Figure 6: Proportion of clients aged ≥ 50 years receiving opioid pharmacotherapy in Australia on a snapshot day 2006-2013

Source: Australian Pharmacotherapy Data (Australian Institute of Health and Welfare, 2014b).

1.1.2.4 Prescription and over the counter (OTC) drugs

The use of sleeping and sedative medication is highest among Australians aged ≥ 65 years, and peaks among those aged 85–89. Those aged 85–89 use these medications at a rate five times that of people aged 45–49. Use among women is 1.5 times greater than among men. Use of benzodiazepines, especially temazepam, nitrazepam and oxazepam is particularly high among older people (Hollingworth & Siskind, 2010).

Use of prescription opioids also peaks among older Australians. Between 2002-03 and 2007-08 oxycodone prescribing increased substantially, particularly among those aged 80+ years (see Figure 7). Between 2002 and 2012, fentanyl prescriptions also increased dramatically among this age group (Roxburgh et al., 2013).

Use of strong opioids may increase endocrine and sexual dysfunction, osteoporosis and hyperalgesia (Baldini, Von Korff, & Lin, 2012). Long-term, high-level use of OTC opioid-containing medicines can lead to gastro-intestinal perforation, clotting disorders and liver and kidney problems (related to the paracetamol and ibuprofen they contain) and codeine dependence (Dobbin, 2008).

A recent study (Veal, Bereznicki, Thompson, & Peterson, 2015) raised concerns regarding the use of opioids by vulnerable older Australians. The study involved a sample of 20,000 older people who were either living in the community and deemed at risk for adverse medication outcomes or living full time in an aged care facility.

Issues highlighted in the study included:

- The high prevalence of opioid use (32%), with 22% receiving regular dosages
- Nearly 12% of regular opioid users exceeded maximum recommended dosages
- Over-reliance on opioid analgesics at the expense of non-opioid analgesics

- Concurrent use of sedatives and opioids was commonplace
- Sedative use was most common among those receiving high dose opioids, increasing the risk of falls and fractures
- Insufficient use of laxatives to prevent opioid-related constipation.

The study concluded that there is a significant evidence-to-practice gap regarding the use of opioids among older Australians (Veal, Bereznicki, Thompson, & Peterson, 2015).

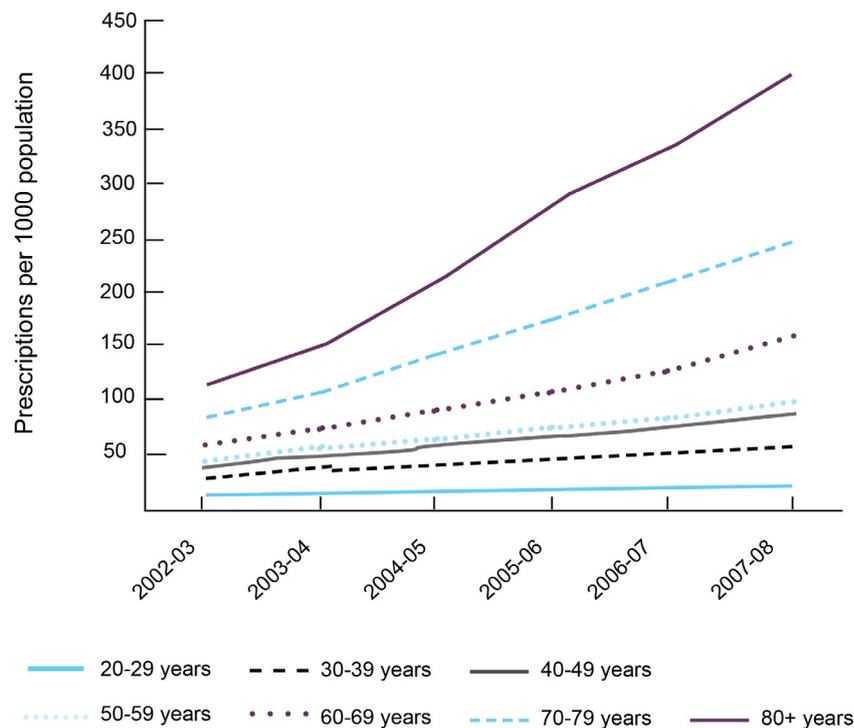


Figure 7: Prescriptions for oxycodone dispensed on the Australian Pharmaceutical Benefits Scheme from 2002 to 2008, per thousand population, by 10-year age groups
 Source: Roxburgh, Bruno, Larance, & Burns (2011).

1.2 Reasons for alcohol and other drug use

Older people use alcohol and other drugs for much the same reasons as the rest of the population, namely:

- For pleasurable effects and social function
- To block out physical pain
- To block out emotional pain.

Changes in alcohol and drug use as people age can occur for a number of reasons, including:

- Increased free time
- Boredom
- Loss of identity
- Loss and grief
- Loneliness.

Increases in disposable income and buying power of many older people may also facilitate greater alcohol and drug consumption and associated problems (Anderson, Scafato, & Galluzzo, 2012).

Evidence regarding the role of retirement on alcohol problems among older adults is variable. There are many studies which suggest that retirement:

- Increases drinking
- Decreases drinking
- Has no impact on drinking (Bamberger, 2014).

It is not retirement itself which exclusively impacts patterns of drinking. Rather, drinking is influenced by a range of individual, social, and environmental characteristics that include:

- Whether retirement was voluntary or involuntary
- The person's gender and health status (e.g., pain or sleep problems)
- A history of problem drinking
- Extent of stressors in retirement (e.g., financial, marital)
- Whether harmful drinking was part of the former workplace culture or post-work social networks
- Whether retirement is perceived by the retiree as a 'loss' or a 'relief'
- The extent of non-work-related support networks (Bamberger, 2014; Kuerbis & Sacco, 2012).

There are also more medications available now to treat more conditions than ever before. Increased awareness of these medications may drive increased use of psychoactive substances as the use of these substances becomes more normalised. Further, some members of the baby boomer generation may hold expectations of a 'quick-fix' which may contribute to greater use of medications (Dowling et al., 2008).

Larger numbers of older people are using alcohol and other drugs in conjunction with prescribed and OTC medications. Some combinations are contra-indicated and can result in adverse outcomes (see Table 3, p21). Many such medications may not provide information about their potential for adverse interactions with alcohol.

1.3 AOD-related preventative measures

Australians are living longer and more healthily. A range of measures (such as health screening, flu shots, diabetes control measures, and preventive medications) have averted many premature deaths. AOD-related preventative measures include:

- Widespread introduction of opioid substitution programs
- Needle and syringe programs
- Enhanced treatments for blood borne and other AOD-related diseases.

However, improved health status and advances in health care can reduce incentives to modify problematic AOD use (Dowling et al., 2008).

1.4 Reasons why older people experience alcohol and other drug harm

AOD-related difficulties among older Australians may result from:

- Social factors, including:
 - ◆ Retirement (and associated boredom and loss of identity)
 - ◆ Increased affordability of AOD
 - ◆ Bereavement (and associated grief, loss and loneliness)
 - ◆ Social isolation
 - ◆ Poverty
 - ◆ Homelessness
- Psychological factors, including:
 - ◆ Depression
 - ◆ Anxiety
 - ◆ Insomnia
 - ◆ Stress
 - ◆ Loneliness
- Physical factors, including:
 - ◆ Chronic painful illness resulting in long-term use of analgesics, alcohol and illicit drugs
 - ◆ Physiological changes leading to differences in drug effects
 - ◆ Comorbid medical / psychological conditions (DrugScope, 2014).

1.5 Physiological changes

As people age, their ability to metabolise drugs decreases. There is also an ageing-related decrease in the body's water to fat ratio. A reduction in body water can:

- Increase drug concentrations
- Reduce liver blood flow
- Decrease liver enzyme efficiency.

The effects of alcohol or other drugs can therefore be more pronounced and longer-lasting at lower thresholds. This can increase susceptibility to AOD problems among older people.

Alcohol, for example, may produce a more rapid depressant effect and increased impairment of motor coordination and memory function in older people (Royal College of Psychiatrists, 2011). For a given quantity of alcohol, older people will generally have a higher blood alcohol concentration compared to younger people.

Individual differences in metabolism can be difficult to predict (Kinirons & O'Mahony, 2004) for:

- Alcohol
- Illicit drugs
- OST
- Prescribed and OTC medicines.

Underlying and / or compounding problems may include:

- Anxiety
- Depression
- Post-traumatic stress disorder
- Drug-induced psychosis
- Schizophrenia
- Delirium³
- Dementia (Royal College of Psychiatrists, 2011).

As people age, the toxic effects of alcohol or drug use and associated diseases (e.g., blood borne viruses) can compromise the body's ability to recover from related illnesses.

Older drinkers are more vulnerable to alcohol-related harm than their younger counterparts, even when drinking at relatively low levels. Older heavy drinkers with health problems are particularly vulnerable (Royal College of Psychiatrists, 2011). Older problem drinkers also have more physical health problems related to their drinking than younger people, even if they drink less and are less alcohol dependent (Gossop et al., 2007).

Excessive drinking among older people is complicated by a reduced capacity to break down alcohol and can cause or aggravate medical problems associated with ageing. Because older heavy drinkers with health problems are at elevated risk, they should be targeted for intervention (Gossop, 2008).

1.6 'Safe' limits for use of alcohol

There has been little research on safe, or low risk, limits for older people's use of alcohol. General population consumption guidelines may not be suitable, as they were developed from research conducted with younger populations. Their applicability to older populations has not been confirmed.

Current guidelines (National Health and Medical Health Research Council, 2009) do not indicate a low risk consumption level for older people, but state that the lifetime risk of harm from alcohol-related disease or injury is minimised for healthy men and women when they drink:

no more than two standard drinks⁴ on any one day.

³ Delirium, for example, may be associated with withdrawal from alcohol or benzodiazepines, but can also be the result of dementia, head injury or serious infection (Royal College of Psychiatrists, 2011).

⁴ A standard drink in Australia contains 10 grams of alcohol.

The guidelines highlight that drinking alcohol increases the risk of falls and injuries and some chronic conditions, and suggest that older people should drink less than the general recommended guidelines and that they should consult their health professionals about an appropriate level of drinking.

Clinicians should be conservative when advising older patients about low risk use of alcohol, illicit drug use, opioid substitution therapy medicines, and prescribed and OTC drugs (see Section 1.11 (p19)).

It is important that advice is tailored to each individual's circumstances and risk factors such as:

- Concurrent medication use
- Physical health
- Psycho-social context.

1.7 Harms

Changing patterns of alcohol and drug use among older people, as highlighted above, have resulted in increased harms.

Victorian ambulance data have found an increase in attendances for intoxication related to alcohol, benzodiazepines and pain medications for people aged over 65. Alcohol intoxication-related attendances nearly trebled from 3.3 individuals per 10,000 in 2004 to 8.2 per 10,000 in 2008 (Hunter et al., 2011).

The number and proportion of older people who received publicly funded treatment for alcohol and other drug problems in Australia also increased over the past decade. Among those aged 60-69 there was a 79% increase in treatment episodes. In 2012/13, there were 4,343 treatment episodes for 60-69 year olds (2.7% of all episodes) up from 2,419 episodes (1.8% of all episodes) in 2003/04 (see Figure 8).

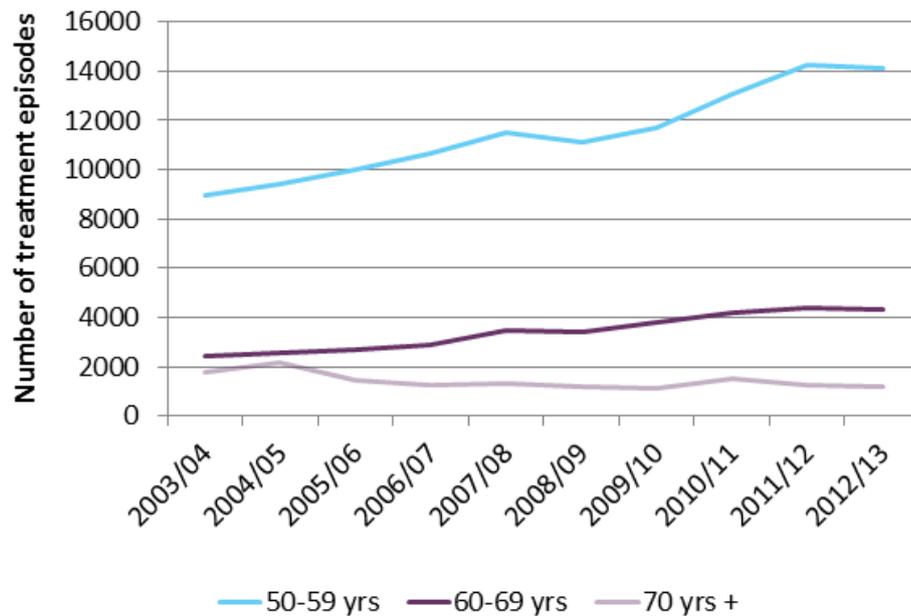


Figure 8: Total number of publicly funded alcohol and other drug treatment episodes for older Australians 2003/04 to 2012/13

Source: National Centre for Education and Training on Addiction (2015b). Secondary analysis of Alcohol and Other Drug Treatment Services National Minimum Data Set (Australian Institute of Health and Welfare, 2014).

Publicly funded AOD treatment episodes for those aged ≥ 50 years rose from 9.6% in 2003/04 to 12.1% in 2012/13, an increase of 26% (National Centre for Education and Training on Addiction, 2015b).

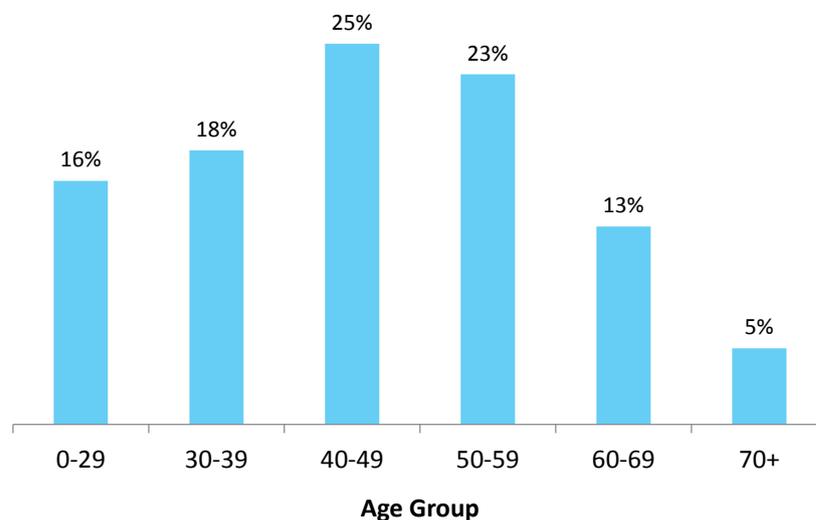


Figure 9: Alcohol-caused hospitalisations by age group, Australia 2009-2010

Source: National Centre for Education and Training on Addiction (2013b). Secondary analysis of National Hospital Morbidity Database 2009/10 (Australian Institute of Health and Welfare, 2011).

Hospitalisations caused by alcohol also increase with age and peak among those aged 40-49 (National Centre for Education and Training on Addiction, 2013c) (see Figure 9). Falls, supraventricular cardiac dysrhythmias and alcohol dependence were the major causes of alcohol-related hospitalisation among Australians aged 65-74 between 1994-2003 (Chikritzhs & Pascal, 2005) (see Table 1).

Deaths due to alcohol-attributable diseases peak among 50-69 year olds (see Figure 10). Older Australians aged 65-74 years living in non-metropolitan areas are more likely to die from alcohol-attributable conditions than city dwellers. Alcoholic liver cirrhosis and haemorrhagic stroke are the major causes of death among this age group (Chikritzhs & Pascal, 2005) (see Table 1).

Table 1: Causes of alcohol-related deaths and hospitalisations

Most common causes of alcohol-related death and hospitalisation among Australians aged 65-74 between 1994-2003 (Chikritzhs & Pascal, 2005)	
<i>Causes of death</i>	<i>Causes of hospitalisations</i>
<ul style="list-style-type: none"> • Alcoholic liver cirrhosis • Haemorrhagic stroke 	<ul style="list-style-type: none"> • Falls • Supraventricular cardiac dysrhythmias • Alcohol dependence

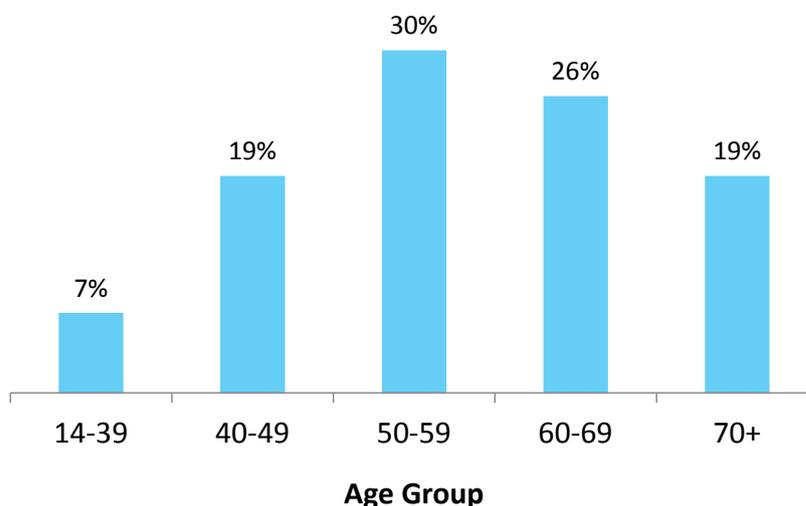


Figure 10: Australian deaths due to alcohol-caused diseases, 2010

Source: National Centre for Education and Training on Addiction (2013b). Secondary analysis of 2010 Australian mortality data (Australian Bureau of Statistics, 2010).

1.8 The spectrum of use and harms

Alcohol and other drug use among older people occurs along a spectrum. At one end of the spectrum are individuals who do not use any alcohol or drugs. Among those who do use alcohol or drugs, some people experience unproblematic use while others may develop a range of problems. Individuals can move backwards and forwards along the spectrum of use (see Figure 11).

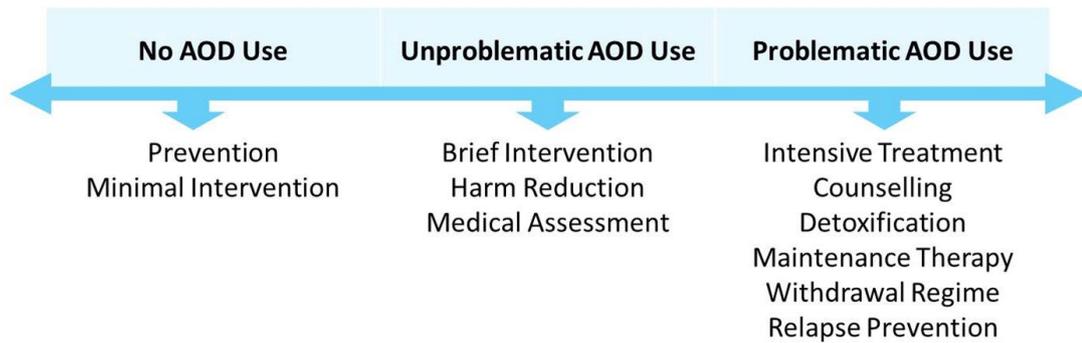


Figure 11: The spectrum of alcohol and other drug use and problems

Different approaches are needed to prevent and reduce harm at various points on the spectrum. Educative measures may be appropriate for non-users or non-problematic users to help maintain the status quo or identify emergent problems. Problems related to intoxication or regular hazardous use (see Figure 12) may respond to brief intervention. Clients who are dependent may require counselling and withdrawal services.

Issues related to problematic AOD use fall into three groups:

- Intoxication
- Regular hazardous use
- Dependence (see Figure 12).

These patterns of problems:

- May be distinct or overlap in the same individual
- Can stem from different contributory factors
- Require different responses and interventions.

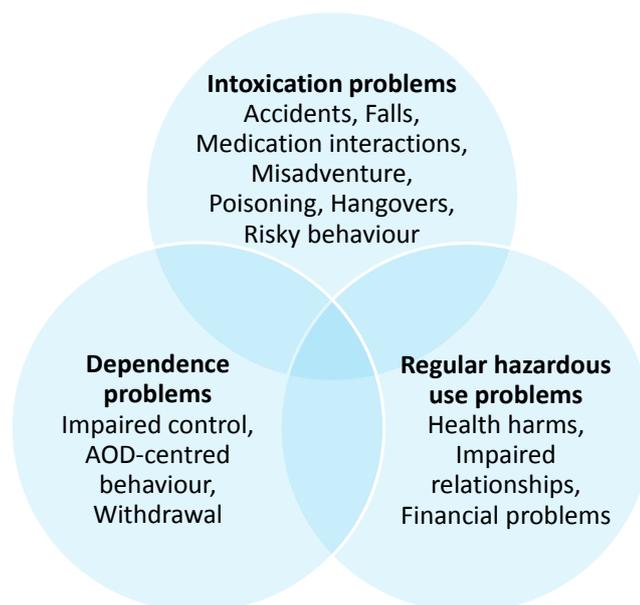


Figure 12: Different types of alcohol and drug problems

1.9 Early versus late onset problems

Older harmful substance users can be categorised as:

- Maintainers
- Reactors (late onset users) (Schonfeld & Dupree, 1991)
- Survivors (early onset users) (Schonfeld & Dupree, 1991).

The maintainer / survivor/ reactor typology particularly applies to alcohol and prescription drugs. The extent to which it also applies to illicit drugs is unclear, as studies to-date have largely overlooked illicit drug use among older populations (Wu & Blazer, 2011).

Three factors could potentially facilitate the uptake of illicit drug use among older people:

- The medicalisation of cannabis for the treatment of pain and other conditions (Leung, 2011) may enhance uptake among older people for non-medical purposes
- As a greater proportion of baby boomers used illicit drugs when they were younger compared with previous cohorts (Han et al., 2009; Wu & Blazer, 2011) they may be more likely to recommence illicit drug use later in life
- The high level of prescription opioid (and OTC) use among older people may act as a pathway to heroin use as has been seen overseas (Dertadian & Maher, 2014; Kolodny et al., 2015; Lankenau et al., 2012; Mars, Bourgois, Karandinos, Montero, & Ciccarone, 2014).

1.10 Multiple morbidities⁵

Multiple morbidities are common among older people experiencing AOD problems. Health care advances have averted many substance-related deaths, and more people are surviving into older age with comorbidities as a result. Ageing is associated with a range of social, psychological and health problems which can be risk factors for, and / or exacerbated by, substance use. These may also lead to the development or continuation of substance use problems to cope with physical or psychological pain / distress (Gossop, 2008).

Multiple morbidities can interfere with physical functioning and emotional, cognitive and social behaviour and result in poorer outcomes. Comorbidities also make assessment and treatment more difficult (Royal College of Psychiatrists, 2011).

1.10.1 Mental health comorbidities

Mental health / alcohol and other drug comorbidities are common across the Australian community (see Figure 13). These comorbidities are also common among older people but widely under-diagnosed (Royal College of Psychiatrists, 2011; Searby, Maude, & McGrath, 2015).

⁵ At the time of writing, work was currently underway on the development of a manual for clinicians whose clients are aged 55 years and older and have a mental illness and / or use substances. The resource is being developed by Building Up Dual Diagnosis Holistic Aged Services (BUDDHAS) under the auspices of the Victorian Dual Diagnosis Initiative.

Table 2: A typology of older users

Group	Characteristics	Case Illustration
Maintainers	<p>This group has continued previously unproblematic use into old age.</p> <p>Ageing-related changes and comorbidities affect the body's ability to absorb, distribute and excrete alcohol and other drugs.</p> <p>Levels of use that may be relatively unproblematic in younger years can become harmful in older age.</p> <p>Age-related changes in metabolism may result in AOD harms later in life.</p>	<p><i>Mrs H is a 66-year-old woman living alone in a retirement village after the death of her husband 6 years ago. On most evenings over the past forty years she has enjoyed 2 large glasses of white wine. She exceeded this amount only on special occasions. Recently she has had a series of falls after returning home from social functions at the retirement village at which alcohol was served. Her GP informs her that her liver enzyme results and blood pressure are both elevated. It appears that Mrs H is not able to metabolise alcohol as well as in the past.</i></p>
Reactors	<p>Usually begin problematic drinking in their 50s or 60s.</p> <p>Can have problems related to intoxication, regular hazardous use or dependence.</p> <p>Tend to have a stronger association with stressful / adverse life events such as bereavement, retirement, marital breakdown and social isolation.</p> <p>Tend to have a better prognosis than survivors.</p> <p>Are less likely to know where to seek help and be too embarrassed to speak with their GP (Royal College of Psychiatrists, 2011).</p>	<p><i>Mr W, a 73-year-old retired pharmacist, lives alone in his own house since his wife's death 3 years ago. He has been experiencing progressive memory loss over the last 2 years along with deteriorating self-care, weight loss and several falls. His daughter is concerned that he is becoming muddled, particularly when driving. His daughter said that Mr W's drinking has gradually increased since his wife's death and he was now drinking at least half a bottle of scotch per day.</i></p>
Survivors	<p>Have a long history of substance use which persists into older age.</p> <p>Often have multiple morbidities.</p> <p>Make up two thirds of older problem drinkers in the US (Rigler, 2000).</p> <p>Are more likely to experience loneliness and depression as a result of their AOD-related problems, having alienated significant others over a long period of time (Schonfeld & Dupree, 1994).</p> <p>May have less self-efficacy than reactors as a result of multiple attempts at treatment (Wadd, Lapworth, Sullivan, Forrester, & Galvani, 2011).</p> <p>Often have better knowledge of the AOD services that are available.</p>	<p><i>Mr B is a 74-year-old man living in rented accommodation with his wife. He has multiple chronic alcohol-related physical problems, which have resulted in many hospital admissions. He has been drinking at least two bottles of wine per day for almost 40 years. He lost his job in his late 50s because of his drinking. His wife can no longer cope with him as a result of his poor hygiene, threatening behaviour, drink driving and poor medication adherence.</i></p>

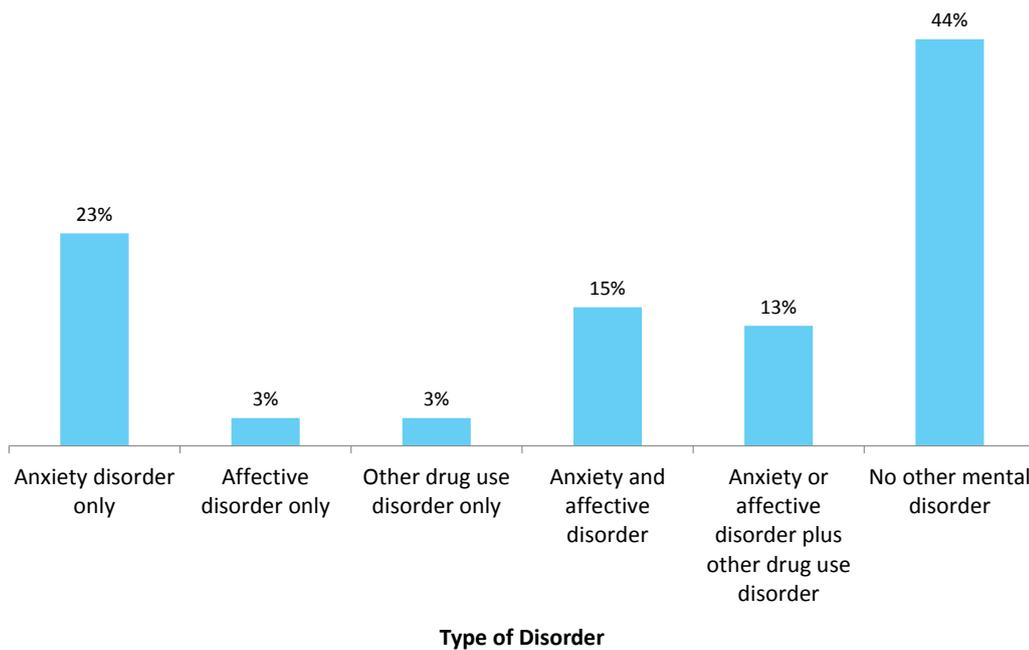


Figure 13: Mental health comorbidities amongst Australians with an alcohol disorder

Source: National Centre for Education and Training on Addiction (2013). Secondary analysis of 2007 National Survey of Mental Health and Wellbeing (Australian Bureau of Statistics, 2009).

Many older people with major alcohol-related problems have a history of depression (Caputo et al., 2012). Alcohol problems can be 3 to 4 times more common among depressed compared to non-depressed older people (Devanand, 2002). The relationship between alcohol and late life depression is complex, but depressed older people who stop drinking improve more than those who continue to drink (Caputo et al., 2012).

One Australian study of males in Geelong reported a U-shaped relationship between alcohol consumption and depression among older people. Depression was most prevalent among non-drinkers and those drinking ≥ 3 drinks per day, and lowest among moderate drinkers (Coulson et al., 2014).

Substance use problems can:

- Worsen or precipitate mental health problems, including dementia
- Trigger the onset of mental health problems in susceptible individuals
- Be an attempt to self-treat or relieve mental health symptoms
- Lead to general life difficulties which can precipitate or worsen mental health problems (Substance Abuse and Mental Health Services Administration, 1998).

Comorbid AOD and mental health problems among older people are often associated with:

- Frequent relapse
- Poor treatment engagement
- Unsatisfactory treatment outcomes overall (Searby et al., 2015).

Other mental health comorbidities among older people with AOD problems include:

- Anxiety
 - Confusional states
 - Sleep problems
 - Post-traumatic stress disorder
 - Drug-induced psychosis
 - Schizophrenia
 - Self-harm
 - Delirium
- (Royal College of Psychiatrists, 2011).

Heavy, prolonged alcohol use may also increase risk of vascular dementia and Alzheimer's disease. In addition, it can have indirect effects on brain function through decreased absorption of thiamine, resulting in problems such as Wernicke–Korsakoff syndrome. Alcohol may also have a direct neurotoxic effect, producing 'alcoholic dementia'. The management of alcohol misuse in patients with cognitive impairment / dementia presents a significant clinical challenge (Royal College of Psychiatrists, 2011).

Case study 1: Mental health comorbidities

Eric is a 64-year old tiler who had been treated for depression by his GP for six years. His GP prescribed an antidepressant, which he had been taking in increasing doses, but his depression was worsening. An assessment by a locum GP revealed he was drinking a carton of full strength beer per day (360 grams or 36 standard drinks) and was alcohol dependent. Following admission to a detoxification facility Eric stopped drinking for five months and his mood improved. However he relapsed and began drinking at former levels. He was again admitted to a detoxification facility and then engaged with a counsellor as an outpatient. One year later Eric was still not drinking, was no longer depressed and was reducing his antidepressant use.

1.10.2 Physical comorbidities

Multiple physical morbidities are largely the norm among older people experiencing severe AOD problems. The physical complications of alcohol use are numerous and manifest in almost all organs of the body (Crome & Bloor, 2005). Problem alcohol and other drug use can cause and exacerbate some medical problems.

Interactions between these morbidities can not only interfere with physical functioning and emotional, cognitive and social behaviour, but can result in poorer treatment adherence and short- and longer-term outcomes (Royal College of Psychiatrists, 2011).

Common physical comorbidities include:

- Injuries related to falls and trauma
- Cardiovascular problems (e.g., hypertension, heart enlargement, heart rhythm and blood clotting abnormalities, hyperlipidaemia, stroke)
- Liver diseases (e.g., fatty liver, fibrosis, infective and non-infective hepatitis and cirrhosis)
- Blood borne diseases
- Irritable bowel syndrome and incontinence
- Dietary deficiencies, diabetes, malnutrition and pancreatitis
- Overweight and obesity
- Seizures and neuropathy
- Sexual dysfunction
- Cancers (particularly mouth, oesophagus, throat, liver and breast)
- Immune system impairments
(Devanand, 2002; Hunter & Lubman, 2010; Royal College of Psychiatrists, 2011; Substance Abuse and Mental Health Services Administration, 1998).

Case study 2: Physical and mental health comorbidities

Frank is a 72 year old single man who had been a long-term heavy drinker (>200 grams of alcohol / day, >20 standard drinks per day) living in unstable accommodation at a boarding house. On presentation to an orthopaedic ward following a fall which badly fractured his arm, he was found to have very high blood pressure and liver cirrhosis. He was very distrusting of hospital staff. A subsequent psychiatric review found that he had a severe generalised anxiety disorder with evidence of significant cognitive decline. A case management meeting was initiated involving orthopaedic, psychiatric, alcohol and other drug, and social work team members as well as his GP.

Frank made a full recovery from his fracture and he found accommodation in an aged care facility. His ongoing care was coordinated by his GP with assistance from psychiatric and alcohol and other drug outreach service staff.

1.11 Interactions with other medicines

Many older Australians are regular users of prescription and OTC medicines. As a result, there is a risk of adverse interactions with other AOD use.

1.11.1 Interactions with alcohol

Alcohol can interact in harmful and unpredictable ways with many prescribed and OTC medications and some herbal preparations (see Table 3, p21). Such interactions may:

- Change the effect of the alcohol and / or the medication
- Occur at low levels of drinking (as low as one standard drink)
- Vary depending on the medications and individual differences.

Alcohol dampens activity in the brain (by depressing the central nervous system). When used with medications or other drugs that have similar effects, these affects can be amplified and increase potential for harm especially if operating machinery or when engaged in other risky activities.

Older people taking medications or other health preparations:

- Should carefully read the labels and pamphlets with their medications (including herbal preparations), to check for harmful interactions with alcohol
- Seek advice from a health professional about potential interactions as some products do not state this on the label or in the information pamphlet. Health care professions should be encouraged to check MIMS or consult with a pharmacist to ensure full and accurate advice is provided
- May need to reduce or cease alcohol consumption
- Need to be very cautious if drinking alcohol while using:
 - ◆ benzodiazepines
 - ◆ methadone (or other forms of opiate substitution)
 - ◆ analgesic patches
 - ◆ other central nervous system depressants
- Are at greater risk of harmful interactions if taking a number of medications (Australian Government Department of Veterans' Affairs, n.d.).

Health care providers should:

- Be aware of the possibility of medication interactions with alcohol
- Advise the client of possible interactions and effects
- Be particularly mindful of potential interactions when prescribing medications for mental health problems, pain and blood pressure.

1.11.2 Interactions with illicit drugs

Illicit drugs can interact with medicines in a range of ways (see Table 4, p22.)

Table 3: Potential effects of medicines used in combination with alcohol (Source: Drug Education Network, 2014)

Type of substance	Potential effects in combination with alcohol
Antidepressants and antipsychotics	Impaired mental skills Worsening of psychiatric symptoms Sedation and impaired breathing Drop in blood pressure Liver damage
Antihistamines	Drowsiness, sedation, dizziness
Sedative hypnotics	Drowsiness Decreased motor skills and breathing Fatal overdose
Antibiotics	Nausea, vomiting, headache Convulsions Liver damage Sedation
Medication to control diabetes	Headache Nausea Reduced diabetes control
Medicines that contain alcohol	Increased alcohol intake Increased intoxication effects
Heart and circulatory system medication	Dizziness Fainting Reduced medication effectiveness
Anticoagulants	Increased risk of bleeding Decreased medication effectiveness
Arthritis medications	Stomach upset including gastrointestinal bleeding Stomach inflammation Increased risk of liver damage
Opioid-based pain medications	Increased sedation Decreased motor skills Overdose
Anti-seizure medication	Decreased medication effectiveness Increased medicine side effects

Table 4: Potential interactions between illicit drugs and medicines (Dean, 2006; Lindsey, Stewart, & Childress, 2012)

Illicit drug	Medicine	Potential resultant interaction
Cannabis	Antidepressants	Mania, fast heartbeat, delirium
	Erectile dysfunction drugs	Heart attack
	Anti-alcohol misuse medicine	Hypomania
	Antipsychotics	Reduced treatment effectiveness
	Sedative hypnotics, pain medicines	Sedation, central nervous system depression
	Antiviral drugs	Reduced antiviral effectiveness
Amphetamine type stimulants (ATS)	Antidepressants	Severely elevated blood pressure
	Anti-seizure medication	Increased likelihood of seizures
	Blood pressure medicines	Reduced treatment effectiveness
	Antipsychotics	Reduced treatment effectiveness
	Urinary alkalinisers	Increased effect and duration of ATS
Heroin	Sedative hypnotics, pain medicines	Sedation, reduced breathing, low blood pressure, fatal overdose

1.12 Falls and other injuries

Alcohol and other drug use is a major risk factor for falls and injuries. Risk is further exacerbated when medicines are used concurrently with alcohol or other drugs and in the presence of comorbid conditions, particularly dementia (Mallet, Spinewine, & Huang, 2007; Royal College of Psychiatrists, 2011).

It is especially important to consider alcohol and other substance use-related problems among clients who present with unexplained falls (Royal College of Psychiatrists, 2011).

Alcohol misuse is an important risk factor for falls and fractures as it can cause:

- Confusion
- Low blood pressure on standing up
- Nerve damage
- Reduced coordination
- Reduced bone mineral density, particularly in combination with smoking (Caputo et al., 2012).

1.13 The experience of stigma

The stigma associated with having an alcohol or other drug problem remains one of the strongest barriers to seeking treatment (Conner & Rosen, 2008). Many older people with alcohol and other drug problems experience the dual stigmas associated with these problems as well as ageing (Doukas, 2011; Royal College of Psychiatrists, 2011; Wadd et al., 2011).

Stigma is particularly felt by older women (Wadd et al., 2011) and people with illicit drug problems, especially those on pharmacotherapy programs (Doukas, 2011; Kelsall, Parkes, Watson, Madden, & Byrne, 2011). Older people may also feel stigmatised by having to attend traditional alcohol and other drug services developed for younger people (Wadd et al., 2011).

Reducing the stigma experienced by older people with alcohol and other drug problems will require improved community and practitioner attitudes towards this group and greater efforts to reduce the sense of therapeutic hopelessness and social exclusion they often experience (Royal College of Psychiatrists, 2011).

In addition, it will be important to enhance program privacy and accessibility by introducing a broader range of service options including home visiting (Wadd et al., 2011).

1.14 Vulnerability to exploitation

Older people with alcohol and other drug problems can be at risk of exploitation as a result of:

- Substance-related disabilities resulting in reliance on others for assistance or care
- The need to rely on strangers for care (sometimes as a result of poor family relationships or estrangement stemming from long-term substance use problems)
- Substance-related cognitive loss reducing their ability to resist or detect coercion and fraud
- Being encouraged or forced to take drugs, or drink excessively, to facilitate exploitation by carers
- Being substance dependent and unable to purchase the substances themselves
- Being regularly intoxicated
(Wadd et al., 2011; World Health Organization, 2006).

It is important for services providing support for older people with AOD problems to be aware of the potential for exploitation and to promote multi-agency partnerships to prevent this (World Health Organization, 2006).

1.15 Groups at particular risk

Groups of older people who are at particular risk of experiencing alcohol and other drug harm include:

1. Aboriginal and Torres Strait Islander peoples
2. People from culturally and linguistically diverse backgrounds
3. Lesbian, gay, bisexual, transgender queer and intersex people
4. Women
5. Injecting drug users.

1.15.1 Aboriginal and Torres Strait Islanders

Substance use among Aboriginal and Torres Strait Islander peoples can:

- Contribute to physical and psychosocial health problems and disadvantage
- Widen the gap between Indigenous and non-Indigenous Australians' life expectancy (Australian Institute of Health and Welfare, 2011b)
- Be understood in the context of a history of dispossession, denial of culture and conflict (Gleadle et al., 2010).

Compared with non-Indigenous Australians, Aboriginal and Torres Strait Islander Australians:

- Have higher rates of tobacco and other drug use
- Are less likely to drink alcohol but are more likely to consume at risky or high risk levels (Australian Institute of Health and Welfare, 2011a, 2011b).

1.15.2 Culturally and linguistically diverse groups

The needs of older people from culturally and linguistically diverse (CALD) backgrounds are not well understood. Prevalence of AOD use in CALD communities is generally lower than the broader population but they are under-represented in treatment services. Reasons for this include:

- Lack of awareness of services
- Language barriers
- Lack of understanding and trust
- Treatment retention problems stemming from:
 - ♦ unrealistic expectations of treatment
 - ♦ inappropriate referrals to multicultural or ethno-specific welfare services that lack necessary AOD knowledge (Drug and Alcohol Multicultural Education Centre, 2010).

1.15.3 Lesbian, gay, bisexual, transgender, queer, and intersex (LGBTQI) people

The prevalence of alcohol and other drug problems among older LGBTQI people has not been well

researched. However, most research concerning lesbian, gay, bisexual and transgender people has found higher rates of alcohol use disorders, illicit drug use and illicit drug use disorders among these populations compared to heterosexual populations. Factors that may account for higher rates of alcohol and other drug problems include: stigma; abuse and victimisation; strained relationships with family and friends; and stresses associated with 'coming out'. Many of these factors are likely to be inter-related; for example the process of 'coming out' may have implications for relationships with family and friends (Ritter, Matthew-Simmons, & Carragher, 2012). This trend may continue in older age.

1.15.4 Women

Older women have some unique AOD risk factors. Older women are more likely to:

- Live longer than men
- Live alone
- Lack financial independence / security
- Have physical risk factors that make them susceptible to the negative effects of AOD (such as having proportionately more body fat) (Blow & Lawton Barry, 2003)
- Experience anxiety and sleep disorders and be prescribed anxiolytic and hypnotic medicines (Hollingworth & Siskind, 2010)
- Experience chronic pain (Pain Australia, 2011)
- Not have their AOD problems detected, resulting in lost intervention opportunities and accumulation of harm over time (Blow & Lawton Barry, 2003).

1.15.5 People who inject drugs

People who inject drugs in Australia are ageing. Many did not anticipate or prepare for old age and retirement (Kelsall et al., 2011). People who inject drugs disproportionately report lower socio-economic status, limited formal education and inadequate housing. These factors contribute to poor physical and mental health (Kelsall et al., 2011).

Difficulties experienced by this group include:

- Health problems
 - ◆ injection-related vascular problems
 - ◆ endocarditis
 - ◆ blood borne diseases
 - ◆ pain
 - ◆ masking of serious health problems as a result of opioid use
- Stigma and discrimination (older people who inject drugs are often vilified and considered beyond help due to their advanced years and may be judged even more harshly than their younger counterparts)

- Pharmacotherapy problems
 - ◆ cost
 - ◆ transport difficulties
 - ◆ lack of flexibility
 - ◆ longer term pharmacotherapy effects
- Involvement in criminality to purchase illicit drugs
- Employment issues (particularly when juggling pharmacotherapy commitments)
- Social isolation and family problems (Kelsall et al., 2011).

Ageing and injecting drug use can combine to create a set of unique issues (Kelsall et al., 2011). The needs of this group will require particular focus by specialist AOD and generalist services alike.

PART 2: PREVENTION AND TREATMENT

Summary

Older people in treatment for alcohol or other drug problems do not achieve worse outcomes than younger people and may do slightly better.

Treatment programs for older people are broadly similar to services provided to other sectors of the population, but may need subtle adaptations and must take account of older people's heterogeneity.

The nature and level of intensity of interventions needs to be tailored to the characteristics of the problems being experienced.

The high prevalence of comorbidities among older people with alcohol or drug problems requires a range of specific approaches.

As a result of the high prevalence of comorbidities among older people with alcohol or drug problems, it is important to have sound referral protocols in place.

Challenges to older people accessing help / treatment may stem from:

- The knowledge, skills and attitudes of health professionals
- Client characteristics or beliefs
- Practical problems of accessibility.

There is a range of strategies which can be implemented to enhance communication with older adults.

Reliable screening tools are available to detect alcohol problems among older people (AUDIT-C and A-ARPS). No similar tools are available for drugs other than alcohol.

Screening programs for older people have not been widely implemented in primary health care and community settings.

Brief interventions have great potential to prevent and reduce alcohol- and other drug-related harm among older people, but their uptake, particularly in primary care settings, has been poor.

Interventions need to be based on the person's readiness to change.

Motivational interviewing can play an important role in enhancing motivation to change risky substance-related behaviours.

Alcohol and drug specialist services play important policy, funding, workforce development and service provision roles in relation to older people and substance use.

2.1 The importance of harm reduction and primary, secondary and tertiary prevention efforts

2.1.1 Harm reduction strategies⁶

Harm reduction involves strategies that can help an older person avoid harms associated with their alcohol or other drug use, without necessarily resulting in a reduction in use. The goal is to work towards less problematic AOD use and involves non-confrontational and non-judgmental approaches which help the person make better decisions and choices.

Helping clients with the problems that are most salient to them (e.g., insecure housing, poor health) can be helpful, even if the client feels unable to stop or reduce their AOD use. This approach can also create opportunities for service providers to establish and maintain relationships with the older adult.

Harm reduction strategies can be used with a range of problems. There are 6 key steps involved in harm reduction interventions.

1. Providing feedback to clients, including:
 - A summary of the harms being experienced as a result of their AOD use
 - Identifying the connection between the presenting problem and AOD use
 - Identifying the manner in which the client's behaviour is contributing to the harms they are experiencing
2. Adopt a collaborative approach to identify harm reduction strategies by:
 - Identifying previously successful strategies
 - Exploring barriers to harm reduction interventions
 - Using motivational techniques
 - Focussing on the behaviours the client wants to change
 - Brainstorming together
3. Helping the client to identify their harm reduction goals. Goals should be SMART.
 - **S**pecific
 - **M**easurable
 - **A**ttainable
 - **R**ealistic
 - **T**ime-limited (short-term)
4. Monitoring the client to see how they are faring in relation to their harm reduction goals and reinforcing progress made
5. Reviewing the goals to see if they continue to be appropriate
6. Re-establishing goals if necessary.

⁶ Section 2.1.1 draws on Seeking Solutions (2004).

2.1.1.1 Health problems

Compared to younger people, older adults are at greater risk of having their health and independence jeopardised by their AOD use, and may feel that they are facing an inevitable decline. Older adults may have also lost contact with former health care providers. Relevant harm reduction strategies include:

- Helping the older adult connect with health practitioners and keep appointments
- Ensuring that the client's care is coordinated among all the agencies involved
- Assisting with transportation
- Helping the older adult recognise and understand the connection between patterns of AOD use and health problems being experienced
- Ensuring pain management needs are addressed.

2.1.1.2 Safety concerns

Intoxication-related safety concerns include falls and fire risk (e.g., leaving the stove on, falling asleep while smoking), drink / drugged driving or blood borne diseases. Harm reduction strategies include:

- Making arrangements through family, friends, volunteers, or neighbours to check on the older adult or assist with transport
- Providing a telephone reassurance service for frail older adults through community or police services
- Ensuring that older people who inject drugs have access to sterile injection consumables.

2.1.1.3 Medication harms

Harm reduction strategies for medication harms centre on educating the older adult about potential interactions between alcohol and other drugs and their specific medications (including OTC drugs, and herbal medicines). Other useful strategies include:

- With the permission of the client, ensuring that the prescriber has an accurate picture of the client's level of alcohol and other drug use
- Working with the prescriber to ensure that the least harmful medications are prescribed.

2.1.1.4 Nutritional problems

Older adults misusing alcohol and other drugs are at a greater risk of malnutrition and consequent illness. Older adults who eat well, compared to those who do not, experience fewer adverse effects from their AOD use, even at moderately high levels of AOD consumption.

Heavy alcohol use can affect an older adult's appetite and nutrient absorption. Money spent on alcohol or drugs may also result in having insufficient money left for food. Strategies to deal with harms associated with poor nutrition may include:

- Encouraging the client to eat when drinking

- Arranging for the client to buy groceries before purchasing alcohol
- Providing help with accessing meal programs (e.g., Meals on Wheels)
- Helping with practical matters that can affect access to proper food (e.g., a broken refrigerator)
- Encouraging attendance at cooking classes for people who live and eat alone to enhance socialisation and learning opportunities
- Encouraging vitamin and mineral supplementation (particularly Vitamin B1 - thiamine).

2.1.1.5 Isolation

Older adults with alcohol and other drug problems may have very few connections to their community, health services, or other social services. Effective harm reduction strategies for reducing older adults' isolation may include:

- Providing outreach services (i.e., going to the person's home)
- Facilitating access to support groups and social support networks.

2.1.1.6 Vulnerability to exploitation

Older people with alcohol and drug use problems can be vulnerable to assault, abuse, and exploitation by family or others. Strategies to reduce this include:

- Helping the client plan how to avoid risky situations (e.g., withdrawing less money when drinking, taking precautions so that others do not see the money)
- Putting safeguards in place (e.g., direct deposit, automatic rent payment)
- Informing the client's bank of the potential for exploitation
- Informing relevant authorities of instances of exploitation.

2.1.1.7 Risky sex

For some older adults, alcohol and other drug use can leave them at risk of sexually transmitted diseases, including HIV / AIDS which are increasing among older Australians (Carman, Grierson, Hurley, Pitts, & Power, 2009). Harm reduction strategies can include:

- Acknowledging that older adults continue to have sexual feelings and can be sexually active
- Providing age-appropriate and non-judgmental information specifically geared to older adults about risky sexual behaviour and methods of sexual protection
- Making condoms easily available in washrooms of health centres, seniors' centres, and bars or other places that older adults may visit.

2.1.1.8 Family problems

In some instances, an older adult may be unable or unwilling to change their substance use behaviour despite the effect it may be having on them or others. In the latter case, the harm reduction goal may be to reduce harms to family members. Relevant harm reduction strategies can

include:

- Educating family members about alcohol and ageing, especially its effects on memory and behaviour
- Helping family members establish appropriate personal boundaries to ensure their safety
- Helping family members develop positive coping strategies and avoid developing AOD problems in their own lives.

2.1.2 Primary, secondary, and tertiary prevention

Reducing alcohol and other drug harm among older people requires attention to the three levels of prevention.

2.1.2.1 Primary prevention

The goal of primary prevention is to protect older people from experiencing AOD-related harm. This includes:

- Education about low risk levels of consumption and the risk of adverse interactions with medications
- Regular screening for risk factors for AOD problems
- Regular screening for the emergence of symptoms of AOD problems
- Information to help recognise and respond to the emergence of AOD problems.

2.1.2.2 Secondary prevention

The goal of secondary prevention is to respond to emerging AOD problems, or risk factors, to prevent the situation from worsening. Appropriate strategies include:

- Brief interventions
- Harm reduction measures
- Enhancing access to social and other activities that do not involve alcohol consumption.

2.1.2.3 Tertiary prevention

The goal of tertiary prevention is to treat and reduce the harm experienced by people with established alcohol and other drug problems. This includes:

- Detoxification programs
- Pharmacotherapy (such as OST and benzodiazepine stabilisation and reduction programs)
- Long-term counselling.

2.2 Does treatment work?

Older people in treatment for AOD problems do not achieve worse outcomes than younger people and may do slightly better (Moy, Crome, Crome, & Fisher, 2011). Reactors tend to do better than survivors in treatment (see Table 2, p16). Factors associated with older age which may enhance a positive prognosis, especially for alcohol problems, include:

- Staying in treatment longer, which older people tend to do
- Having a supportive family / friends
- Being less likely to have family and friends who condone AOD use (Satre, Mertens, Arian, & Weisner, 2004).

Treatment outcomes for older clients could be improved by:

- More specifically designated services for older people
- Interventions tailored to older individuals' needs
- Meeting transport and healthcare costs
- Minimising discrimination and stigma (Crome, Sidhu, & Crome, 2009).

2.3 Features of successful interventions

2.3.1 Alcohol and other drug problems

Evidence-based AOD prevention and treatment services for older people:

- Are broadly similar to services provided to other sectors of the population
- May need subtle adaptations of widely used approaches
- Need to take account of older people's heterogeneity.

Successful interventions for older clients with AOD problems rely on:

- A client-centred, empathetic, non-judgmental and trusting relationship between client and practitioner
- The client seeing the intervention as a mutual exercise where the client makes active decisions
- Clients being supported to develop a sense of responsibility for their AOD use and the self-confidence to believe they can change
- Thorough assessment with a view to:
 - ◆ building rapport
 - ◆ gathering information to guide treatment planning

- ◆ providing clients with feedback to help develop alternative responses
- ◆ personalising the health effects of their AOD use
- ◆ monitoring progress
- Tailoring intervention intensity and duration to the client's degree of dependence or AOD harm (see Table 5 and Figure 14).

Table 5: Tailoring the intervention to patterns of AOD harm experienced by older people
(Babor & Higgins-Biddle, 2001; Heather, 2003).

Type of behaviour / problem	Intervention / response
No use / unproblematic use	Prevention activities, information about particular AOD-related risks and strategies to adopt if use becomes problematic
Risky or hazardous use	Brief interventions, discussion of harm reduction measures, medical assessment
Harmful use / dependence	Intensive treatment, counselling, detoxification, maintenance therapy, relapse prevention

As alcohol and other drug problems become more severe, more intensive interventions are required. These range from low intensity prevention interventions for those who are not using AOD problematically, through to high intensity interventions for harmful users or those who are dependent (see Figure 14).

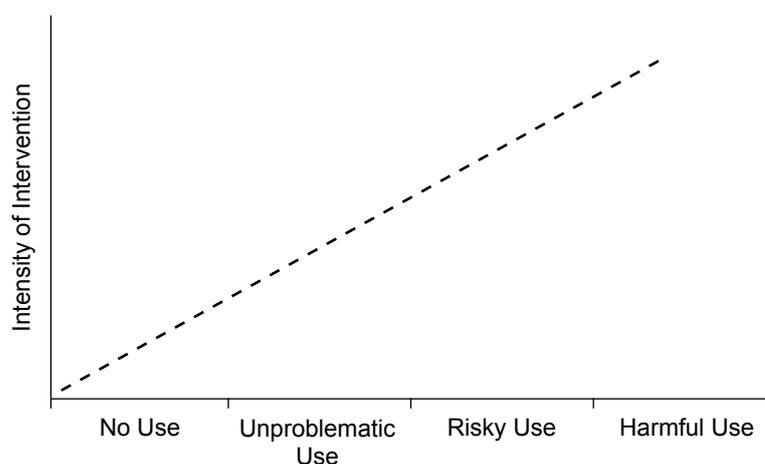


Figure 14: The intensity and level of intervention necessary for different patterns of use

2.3.2 Responses to comorbidity

Outcomes for older adults with comorbid substance use and physical / mental health problems are improved when their problems are approached in a holistic and coordinated way.

In relation to mental health comorbidities, there are a number of factors that may act as barriers to alcohol and other drug and mental health agencies routinely screening, assessing and treating these co-occurring disorders. Potential barriers to routine screening, assessment, and treatment of comorbid conditions, and possible strategies to address them are identified in Table 6 (Croton, 2007).

Table 6: Barriers and strategies to address routine screening, assessment, and treatment of comorbid conditions
(Source: Croton, 2007)

Barriers	Strategies
<p>Lack of awareness of:</p> <ul style="list-style-type: none"> • prevalence and harms associated with co-occurring disorders • likely interactions between disorders • treatment implications. 	<p>Provide this information in multiple formats, for example:</p> <ul style="list-style-type: none"> • training sessions • staff orientation procedures and manuals • client and carer education packages. <p>Enhance the capacity of agencies to record the results of their clients' dual diagnoses screening.</p>
<p>Perception of added work, especially when clinicians may feel overwhelmed by multiple demands, stresses and paperwork, or are change-weary and change-wary.</p>	<p>Promote the view that the goal is more effective, rather than added, work – that recognising and addressing co-occurring disorders is likely to lead to more successful treatment of target disorders.</p> <p>When introducing a new screening or assessment form, take the opportunity to review and simplify existing assessment forms and processes and remove some of the existing paperwork burden.</p>
<p>Lack of familiarity with using screening tools and difficulty integrating their use into routine practice. Clinician concerns that client engagement may be compromised by formal screening for a disorder that the client hasn't presented for help with.</p>	<p>Provide information about the rationale for screening and assessment.</p> <p>Provide training, modelling and clinical supervision around seamlessly integrating screening into routine practice.</p> <p>Include careful explanation to clients of the rationale for and confidentiality of screening.</p>
<p>Clinicians may lack skills, knowledge and confidence in their ability to provide appropriate treatment for a co-occurring disorder and be reluctant to ask questions of the client that would lead to the identification of that disorder.</p>	<p>Provide education, training and realistic evidence for optimism about effectiveness of treatment.</p> <p>Address clinician 'self-efficacy' about providing effective treatment.</p>
<p>Lack of clarity about scope of practice (e.g., some AOD workers may have anxiety about whether it is within their scope of practice to conduct a detailed risk assessment).</p>	<p>Clarify explicit scope of practice guidelines and treatment manuals.</p> <p>Promote tools which contain an integrated risk assessment (e.g., PsyCheck).</p>

Table 6 cont. on next page

Table 6 cont.

Barriers	Strategies
Implication of current 'wrong practice'.	Reframe the development of integrated screening, assessment and treatment as an evolutionary step towards more effective treatment approaches.
Need for changes to practice, language, beliefs, values, and client exclusion criteria.	Use policy to reinforce that addressing co-occurring disorders is core business for both mental health and AOD treatment agencies.
<p>Stigma of client group – two relapsing, highly stigmatised disorders in the one individual.</p> <p>The clinician's own cognitive dissonance (e.g., to address my client's substance use or mental health issue, it is necessary (at some level) to examine my own substance use or mental health issues).</p> <p>History of own substance-related or mental health-related trauma.</p>	<p>Encourage treatment providers to identify their own attitudes and feelings evoked by dealing with the disorder.</p> <p>Provide integrated treatment-oriented clinical supervision.</p>
Lack of knowledge of the 'opposite' treatment system, its strengths, differences and constraints on service.	<p>Provide opportunities to understand and maximise formal and informal contacts through:</p> <ul style="list-style-type: none"> • Rotations and placements with collaborative services • Joint training • Routine provision of service from other agencies • Worker-developed protocols • Co-location • Scheduled, regular interagency managerial and clinician meetings.

Other comorbidity response options include:

- Adopting a 'no wrong door approach' in which older people can get help for a range of problems regardless of the service initially contacted
- Ensuring the health and welfare workforce has essential knowledge and skills about AOD problems, ageing and multiple morbidities
- Enhancing inter-professional practice
- Improving primary care, ageing and specialist drug service coordination
- Using specialist drug workers in consultation, liaison and education roles with other services
- Ensuring funding arrangements support services for older people with multiple and complex needs
- Developing maps of local service referral pathways
- Encouraging consistent approaches to screening, assessment, clinical notes, referral, care coordination, case management, client information, data sharing and training between agencies
(Nicholas & Roche, 2014).

2.4 Challenges to accessing help / treatment and responses

There is an ongoing need for workforce development approaches to ensure that practitioners fully understand the particular needs of older people with AOD problems, and are supported to meet them (DrugScope, 2014). Some of these challenges and potential are outlined in Table 7.

Table 7: Challenges and strategies for accessing help / treatment and responses

Challenges	Affects		Service Responses
	Health Professionals	Clients	
Awareness and Attitudes			
Attribute problems to ageing, or concurrent illnesses, rather than AOD-related causes	✓	✓	<p>Recognise older people with substance misuse problems are not a homogenous group</p> <p>Provide services and treatment which are relevant and responsive to individual needs</p> <p>Education for healthcare professionals</p>
Lack awareness that AOD problems affect older people	✓	✓	<p>Develop policies and practices which raise awareness of AOD problems in older populations and challenge traditional perceptions / attitudes towards old people and AOD use</p>
Believe it is too late to change	✓	✓	
Believe it is wrong to 'deprive' older people of their 'last pleasure in life'	✓	✓	
Be reluctant to ask questions due to embarrassment	✓	✓	<p>Ensure there are staff members who are interested, experienced and competent in working with older adults</p>
Lack confidence to intervene	✓		<p>Universal screening</p>

Table 7 cont. on next page

Table 7 cont.

Challenges	Affects		Service Responses
	Health Professionals	Clients	
<p>Awareness and Attitudes (cont.)</p> <p>Be reluctant to ask for help or disclose problems because they feel:</p> <ul style="list-style-type: none"> • they shouldn't need support • embarrassed about having these problems at an older age • reluctant to re-engage with services if they think that they have 'failed' 		✓	<p>Develop a culture of respect for older clients</p> <p>Offer options of one-to-one counselling and group work</p> <p>Maintain privacy and confidentiality</p>
Diagnostic Tools			
Lack the ability to identify signs and symptoms of AOD problems in older people	✓		Take a broad, holistic approach that emphasises age-specific psychological, social and health problems
Rely on self-diagnosis and / or inadequate diagnostic tools	✓	✓	Ensure that services have age-specific diagnostic tools that are appropriate for clients who may have cognitive impairment
Have cognitive problems, such as substance-induced amnesia or underlying dementia		✓	
Access, Equity, and Quality			
Transport or mobility problems (particularly in communities lacking public transport)		✓	Ensure equity of access (i.e., services for older people are given the same priority as other groups and are physically accessible to older people)
Hearing or language difficulties		✓	<p>Create outreach services</p> <p>Involve interpreters and other communication aids where possible</p> <p>Explain issues in understandable terms</p>

Table 7 cont. on next page

Table 7 cont.

Challenges	Affects		Service Responses
	Health Professionals	Clients	
Access, Equity, and Quality (cont.)			
Limited time availability (e.g., having to care for a spouse, relative, friend or grandchild; key performance indicators, workload)	✓	✓	Plan and develop flexible and adaptable services in consultation with consumers Prioritise the treatment of alcohol and other drug problems as part of a broad, holistic treatment approach
Mixed aged services (some older people may find younger clients hectic, chaotic or intimidating)		✓	Offer age-specific, supportive, non-confrontational programs that: <ul style="list-style-type: none"> • aim to build or rebuild the client’s self-esteem • focus on coping with depression, loneliness and loss (e.g., death of a spouse, retirement) and rebuilding the client’s social support network
Support			
Not knowing where to refer / turn for help	✓	✓	Create linkages with medical services, aged services and other settings for referral into and out of treatment, case management, and community support
Colluding family members	✓	✓	
Reversal of the parent-child dynamic ⁷	✓	✓	
Want to continue using		✓	

Sources: DrugScope (2014); Fry (2007); Schonfeld & Dupree (1995); Substance Abuse and Mental Health Services Administration (1998); Dowling et al. (2008); Wadd et al. (2011); Royal College of Psychiatrists (2011).

7 This occurs when the adult child sacrifices his or her own needs in order to accommodate and care for the logistical or emotional needs of the aged parent when taking on caring roles. They may forego a range of experiences and may develop a range of emotional problems.

2.5 Enhancing communication with older clients

Enhancing communication with older clients with alcohol and other drug problems draws on skills which clinicians regularly apply when interacting with older people. These include:

1. Recognising risks of stereotyping older clients which can lead to inappropriate and demeaning interactions
2. Avoiding overly simple or patronising language (e.g., terms such as “honey” or “darling”)
3. Asking the client how he or she would like to be addressed and introduced to others
4. Using surnames and formal terms of address until given permission to do otherwise
5. Maintaining eye contact, rather than focusing on other things (e.g., client notes or a computer screen)
6. Avoiding looking or sounding impatient
7. Ensuring the environment is quiet and uncluttered
8. Facing older adults when speaking with them, with your face at the same level as theirs
9. Paying close attention to sentence structure when conveying critical information
10. Putting individual pieces of information into separate sentences and using direct, concrete, actionable language
11. Using visual aids to clarify and reinforce key points
12. Asking open-ended questions (e.g., “Tell me about how...”)
13. When others are present, including the older client in the conversation and avoiding referring to the client in the third person
14. Sharing decision making and providing complete and impartial information about the pros and cons of each intervention option
15. Outlining the issues that need to be discussed with the client and presenting them one at a time
16. Checking that the client understands what is being said
17. Cautiously using humour and direct communication styles with older clients from culturally and linguistically diverse backgrounds, as this may be seen as condescending and disrespectful
18. Respecting the client’s privacy and personal space and ensuring the security of the client’s possessions
19. Using shorter, informal sessions rather than longer sessions
20. Respecting the client’s spiritual concerns and desire to discuss meaning and purpose in life.

Sources: Substance Abuse and Mental Health Services Administration (1998); The Gerontological Society of America (2012).

2.6 Primary health care and community services

Many primary health care and welfare agencies are well placed to provide support and intervention for older people, including screening, prevention, harm minimisation and early intervention (National Centre for Education and Training on Addiction Consortium, 2004). The general practice setting is particularly important in this regard.

2.6.1 Screening

Screening programs for older people have not been widely implemented in primary health care and welfare settings. This is largely a result of a lack of tools to cater for the unique and often complex needs of older people (Bright, Fink, Beck, Gabriel, & Singh, 2013).

After the age of 60 every adult should be screened for AOD problems as part of their regular physical examination. Screening, or rescreening, should also occur if the symptoms listed in Table 8 are present or if the older person is undergoing major life changes or transitions.

Table 8: Triggers for screening older people for alcohol and drug problems

Source: Substance Abuse and Mental Health Services Administration (1998).

Triggers to Screen for AOD Problems
Sleep complaints; observable changes in sleeping patterns; unusual fatigue, malaise, or daytime drowsiness
Apparent sedation
Cognitive impairment, memory or concentration disturbances, disorientation or confusion
Seizures, malnutrition, muscle wasting
Liver function abnormalities
Persistent irritability (without obvious cause) and altered mood, depression, or anxiety
Unexplained complaints about chronic pain or other somatic complaints
Incontinence, difficulty urinating
Poor hygiene and self-neglect
Unusual restlessness and agitation
Complaints of blurred vision or dry mouth
Unexplained nausea and vomiting or gastrointestinal distress
Changes in eating habits
Slurred speech
Tremor, motor incoordination, shuffling gait
Frequent falls and unexplained bruising

AUDIT-C is a 3 item alcohol screening tool that can help identify persons who are hazardous drinkers or have active alcohol problems. It is a modified version of the 10 question AUDIT instrument and can accurately detect alcohol problems among older people if cut off points are tailored to this age group (Aalto, Alho, Halme, & Seppä, 2011).

While AUDIT-C is an accurate tool to detect alcohol problems it does not detect:

- Other drug problems
- Use of other medicines
- Other comorbidities.

The Australian Alcohol-Related Problems Survey (A-ARPS) is an age-specific 10 minute pencil and paper or online screening and education tool that reliably identifies hazardous and harmful patterns of alcohol use among older people (Bright, 2011). It takes into account the client's:

- Quantity and frequency of alcohol consumption
- Age and gender
- Medical history
- Medication use
- Symptoms
- Functional status
- Binge drinking and drink-driving risks
- Risk of mixing alcohol with medication (Bright et al., 2013).

A-ARPS helps clinicians identify if a client's medications or health conditions could be affected by the amount of alcohol they drink (Bright et al., 2013). A-ARPS is discussed more fully in Part 3.

Laboratory testing can also be helpful in detecting alcohol problems among older people. In particular, mean corpuscular volume (MCV) and liver function tests such as gamma-glutamyl-transpeptidase (GGT) are sensitive markers to detect alcohol misuse among older populations (Caputo et al., 2012).

To-date no equivalent screening process has been developed for older people's use of drugs other than alcohol. Screening tools such as the Alcohol, Smoking and Substance Involvement Screening Test (ASSIST) may be of assistance but have not been validated in older populations. There are a number of characteristics of the ASSIST tool which may render it insufficiently sensitive to detect alcohol and other drug problems among older people.

For example, in assessing the impact of AOD use on fulfilling usual roles, the scoring of ASSIST may not take into consideration role changes that are associated with ageing. Equally, assessing the extent to which others have expressed concern about the older person's AOD use may not take into consideration social isolation which may limit the ability of others to express this concern.

Nevertheless, research is underway to determine if ASSIST can be adapted to be more sensitive to detecting AOD problems among older people.

2.6.2 Brief interventions

Brief interventions involve screening, assessment and feedback to prevent and reduce risky AOD consumption (Haber, Lintzeris, Proude, & Lopatko, 2009). They range from five minutes of advice in the primary care setting ('minimal intervention') to 5-6 sessions of counselling, more suitable for AOD specialist settings ('brief therapy').

Brief interventions in primary care:

- Are cost-effective
- Can be delivered in a time-limited way
- Involve one or more sessions of between 5 and 30 minutes
- Usually involve motivational interviewing counselling techniques (see below)
- Can be offered to people who have not sought treatment or assistance but have been identified through routine screening as risky users
- Inform people that they may be at risk of harm and encourage strategies to reduce risk (Anderson, Chisholm, & Fuhr, 2009; Haber et al., 2009; O'Donnell et al., 2014).

Six common elements of brief interventions delivered in primary care settings have been identified with the acronym FRAMES (Miller & Sanchez, 1994).

F eedback	Provide feedback about the risks associated with AOD use
R esponsibility	Emphasise the client's personal responsibility and choice to reduce AOD use
A dvice	Provide explicit verbal or written advice to the client about changing hazardous AOD behaviour
M enu	Provide the client with a Menu of alternative strategies and self-help options to help find an approach that is appropriate for them
E mpathy	An empathic, warm and reflective approach adopted by the clinician
S elf-efficacy	Reinforce and enhance the client's belief in their ability to complete tasks and reach goals

Despite its potential, the uptake of AOD brief interventions in primary care settings has been poor (Roche & Freeman, 2004; Swan, Sciacchitano, & Berends, 2008).

2.6.3 Referral

While successful interventions can occur in primary health and welfare settings, sometimes referral is necessary. A low threshold for referral for comprehensive medical assessment for older people experiencing AOD harm is needed, due to:

- Ageing-related physiological changes which make them vulnerable to medical conditions
- Increased likelihood of health problems as a result of longer exposure to AOD
- The risk of withdrawal syndromes if use is ceased or abruptly reduced (particularly alcohol, prescription drugs such as benzodiazepines or opioids).

Clients may need referral to specialist agencies if they require:

- Management of intoxication, detoxification or withdrawal
- Pain management
- Pharmacotherapy treatments
- In-depth counselling
- Treatment of complex psychiatric or other comorbidities
- Follow up or review
(National Centre for Education and Training on Addiction Consortium, 2004).

Once medical / specialist assessment has occurred, the client's AOD issues may be able to be addressed in non-medical settings. On-going inter-agency case management may be needed.

In many parts of Australia there are few options available to refer clients to services such as detoxification and rehabilitation which are established specifically to cater for the needs of older people. Consequently, older clients may be required to use services which include younger people, whom older people may regard as 'hectic', or 'chaotic', or intimidating (Wadd et al., 2011). The identification of referral services should be undertaken in consultation with the client and formalised in a referral letter (Carmichael, 2001).

Referral letters should contain:

- Client detail: name, age and date of birth, address and contact details, and signed consent
- Current issues: reasons for presenting at the service being referred from
- Service requested from agency
- Requests for any feedback or follow-up and how this should be arranged
- Details of ongoing services that will be provided by referring worker or their agency.

Referral guidelines can be extremely useful if developed collaboratively among agencies involved in client referrals. Guidelines should:

- Be developed by those who have to implement them
- Cover all types of appropriate referral, the process of information exchange and feedback
- Serve as the basis for client-centred shared care and cover the roles and responsibilities of services
(Carmichael, 2001).

2.7 Assessing readiness to change

Many contemporary approaches to helping older clients with AOD problems are underpinned by the Trans-Theoretical Model (TTM) of behaviour change (Prochaska, 1991; Prochaska, DiClemente, & Norcross, 1992). This approach suggests that people using AOD in risky or harmful ways are in one of five stages of change (SOC). Interventions are geared to their SOC.

A description of the five stages of change (adapted from Jarvis, Tebbutt, & Mattick, 1998) appears below.

Stage 1: Pre-contemplation

Those in the pre-contemplation SOC lack recognition of the risky or harmful nature of their AOD use and have no intention of changing their behaviour.

Case study 3: Pre-contemplation

Daryl is a 67-year-old truck driver who presented to his GP after his wife Sarah “told him to go and get his dope problem sorted out”. Daryl’s heavy, almost daily, use of cannabis dates back to his early 20s. He has recently tested positive for cannabis on two occasions at random drug testing stations (RDTS) while driving a car and is at risk of losing his truck licence and livelihood. He is also spending \$150 per week on cannabis, which is putting a strain on household finances. He believes that he was just unlucky to get caught at the RDTS and doesn’t want to reduce his cannabis use. He said:

“Everyone does it, it’s never done me any harm, I enjoy it. Sarah needs to lighten up”.

His GP explored some of the positive and not so positive effects of his cannabis use (see motivational interviewing below). She also advised him to avoid breath-holding or deep inhalation to reduce the harm from smoking and gave him some resources to use if he wanted to stop or reduce his cannabis use in the future.

Stage 2: Contemplation

In the contemplation stage individuals begin to recognise the negative consequences of their AOD use, but do not change it. People in this stage are ambivalent about change and may feel trapped but don’t act.

Case study 4: Contemplation

Carol, a 58-year-old retired physiotherapist, began drinking heavily two years ago after the sudden death of her husband. She attended a hospital emergency department with abdominal pain which was diagnosed as alcoholic gastritis. She was drinking a bottle and a half of red wine per day. She said:

“I know it’s not good for me and I should stop, but I enjoy it. I like a wine in front of the telly in the evening”.

Carol was referred to the hospital drug and alcohol worker. He explored Carol’s ambivalent feelings and beliefs about her drinking. He also informed her that tests showed that her liver was being damaged and that her blood test results were more elevated than 95% of the population.

Stage 3: Preparation

Clients in the third SOC, the preparation stage, are committed to changing their behaviour and may have already made a previous attempt to do so. At this point clients believe that the negative consequences of AOD use outweigh the benefits.

Case study 4 (cont.): Preparation

The diagnosis of alcoholic gastritis had come as a shock to Carol and had tipped the balance about how she saw the pros and cons of her drinking. When she got home from the hospital she made an appointment with her GP for 10 days later to discuss the issue. Four days after returning home she started drinking again, although not quite at the same level as before. She had felt much better when she was not drinking and was concerned that her gastritis would return. She said:

“I’d like some help with cutting back on the booze”.

Her GP helped Carol to work out what her goals were. They used the SMART acronym to help with the development of her goals. The goals were:

- ➔ Specific
- ➔ Measurable
- ➔ Attainable
- ➔ Realistic
- ➔ Time-limited (short-term).

Carol decided that she wanted to have no more than 2 small glasses of wine per day with one alcohol-free day per week for the next 3 months.

Stage 4: Action

During the Action stage the client implements measures to reduce or stop AOD use.

Case study 4 (cont.): Action

Carol's GP gave her some written materials with hints about keeping track of, and reducing, her alcohol intake. Her GP gave her a chart to monitor her drinking in standard drinks. She decided to do a number of things:

- ➔ Keep track of how much she was drinking at night
- ➔ Alternate alcoholic drinks with non-alcoholic ones
- ➔ Catch up with her friends in the evening, rather than staying home alone drinking
- ➔ Dilute her wine with sparkling mineral water
- ➔ Offer to be the designated driver whenever she went out with her friends
- ➔ Develop strategies to get herself back on track if she started drinking heavily again
- ➔ Take 100mg of Vitamin B1 (thiamine).

Stage 5: Maintenance

At this stage the client has changed their AOD use and is sustaining that change. During this stage a large number of clients will relapse and return to an earlier stage of change.

Case study 4 (cont.): Maintenance

Carol continued to see her GP fortnightly. After three months, Carol and her GP did a 'stocktake' of how things were going. Overall, Carol had kept to her plan for most weeks. Christmas and New Year occurred during this period and she didn't stick strictly to her plan over that time. On the other hand, on some weeks Carol had two or three alcohol free days per week. She felt like she had more energy, her sleep had improved and she had no symptoms of gastritis. Her GP informed her that her blood tests had almost returned to normal.

Carol and her GP developed some more strategies to prevent and manage relapse. These included:

- ➔ Monthly follow-up visits with the GP
- ➔ Avoiding being at home alone each night of the week
- ➔ Spending the money she had previously spent on alcohol on treats for herself.

Clients may progress sequentially through these stages, however this is the exception rather than the rule. They may relapse and return to an earlier stage several times before they achieve their goals. Nevertheless each time this happens, they gain new knowledge about their behaviour and will be able to apply that in the next attempt (Jarvis et al., 1998).

The stages of change cycle is demonstrated diagrammatically in Figure 15.

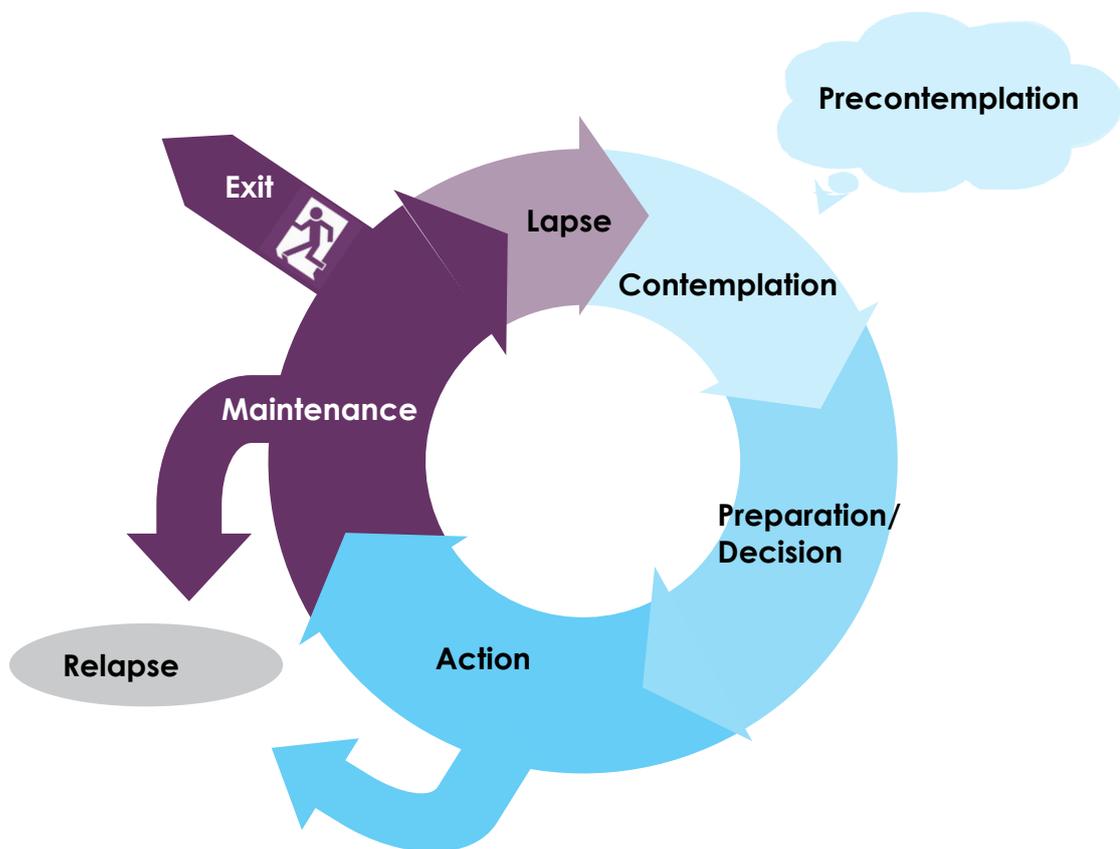


Figure 15: The stages of change cycle

The contemplation ladder (or ladder of change) can be a useful tool to identify which stage of change an older person is currently in (Biener & Abrams, 1991; Rustin & Tate, 1993). The client places a mark at the position of the ladder that best describes their current intentions. This makes it easier to work out where the client is at and to record their changes in the stages of change (see Figure 16).

The Ladder of Change

Please mark a cross on the rung of the ladder that best describes you.



Figure 16: The Ladder of change

2.8 Motivational interviewing

Motivation interviewing (MI) involves enhancing a client's motivation to change risky AOD behaviours. Motivation can be influenced and it fluctuates in response to clinician style. Authoritative or paternalistic approaches increase clients' resistance to change.

Collaborative relationships which respect client autonomy and use the client's own abilities to change are most likely to be successful (Hall, Gibbie, & Lubman, 2012). Motivational interviewing can be linked to the Stages of Change model discussed above.

There are four key principles for the use of MI (Miller, Rollnick & Butler, 2008 as cited in Hall et al., 2012). These are represented by the acronym RULE (see p49).

Resisting the righting reflex⁸

The righting reflex often inadvertently reinforces motivation to maintain the status quo. Most people resist persuasion when they are ambivalent about change and will respond by strengthening their resolve not to change.

Understanding client motivations

It is the client's own reasons for change, rather than the clinician's, that will ultimately lead to behaviour change. Openly exploring the client's motivations for change helps the clinician better understand their motivators and barriers.

Listening with empathy

Effective listening skills are essential to understand what will motivate the client as well as the pros and cons of their situation.

Empowering the client

Client outcomes improve when they draw on their knowledge about what has succeeded in the past. A truly collaborative therapeutic relationship is a powerful motivator. Client benefits are maximised when the clinician is confident that change is possible.

If a clinician has more time, the following four additional principles can be applied within a longer therapeutic intervention (Hall et al., 2012).

Express empathy

Empathic communication involves reflective listening skills and seeking to understand the client's perspectives, thoughts and feelings without judging, criticising or blaming. Without condoning the problematic behaviour, the clinician creates an open and respectful exchange with the client.

Develop discrepancy

Assisting clients to identify discrepancies between their current behaviour and future goals or values about themselves as a person, partner, parent, or worker is a powerful motivator that helps 'tip the balance' toward change. Exploring the pros and cons of change can help a client develop discrepancy.

Roll with resistance

When clinicians attempt to move a client towards change too quickly, particularly if using a coercive or authoritative approach, they often encounter resistance. Rolling with this resistance involves reflecting the resistance back to the client, emphasising their choice to change or not ('it's up to you').

Support self-efficacy

Many older people with AOD problems have made their own attempts to change and been unsuccessful.

Highlighting the client's strengths and reflecting on times in their life when they have successfully changed can be very valuable. The practitioner's belief in a client's ability to change is a powerful way to promote self-efficacy, and in doing so can help the individual develop the confidence that they are capable of change.

8 The righting reflex describes the tendency of clinicians to advise patients about the right path for good health.

2.9 Relapse prevention and management

Lapses and relapses occur frequently among older people who are trying to change problematic AOD behaviour. A lapse occurs when a person initially achieves their AOD-related goals and has a lapse before getting back on track. If a person has a lapse, but instead of getting back on track with their goals returns to a pre-intervention level of use, this is a relapse. Principles that guide relapse prevention include encouraging the client to :

- Undertake more positive activities
- Develop coping skills to manage high risk situations
- Make lifestyle changes to decrease AOD use
- Be ready to interrupt lapses so that they do not lead to relapses and potential harms are minimised (Alcohol and Other Drug Education and Training Unit, 2013).

Relapse / lapse management strategies can include:

- Contracting with the client to limit the extent of use
- Contacting the therapist as soon as possible after the lapse
- Evaluating the situation and identifying the triggers that preceded the lapse
- Reframing a relapse as a hiccup, a learning opportunity, or a temporary setback
- Using previously learnt problem solving strategies
- Using positive self-talk to prevent a lapse becoming a relapse
- Utilising a previously negotiated support network (e.g. friends, family, doctor, or 24-Hour Alcohol and Drug Information Service)
- Providing simple written instructions (for example a lapse coping card) to refer to in the event of a lapse (Alcohol and Other Drug Education and Training Unit, 2013).

2.10 The role of AOD specialist services

There are important roles for AOD specialist services to play in relation to older people and alcohol and drug problems. Some of these roles are complementary to the roles and support that can be provided by more generic health care services and primary care. Others are specific to the specialist AOD sector.

For specialist AOD services to better cater to the needs of older people, a range of responses and actions are required. These include the following:

1. Policy

It is important that all AOD specialist services have in place appropriate policies that recognise the growing and different needs of older members of the community. Each service should have clear and explicit policies that address the ways in which their service and their operations are sensitive to the needs of older people. This includes the physical layout and structure of services, appropriate and

sensitive assessment protocols, the recording of appropriate details regarding older people's needs, close collaboration with other sectors, and the delivery and oversight of services designed and tailored to the needs of older people.

2. Funding

Funding arrangements should reflect the growing impost on AOD specialist services of older people with AOD problems, with funds specifically allocated for the needs of this segment of the population. This entails recognition that older adults may require longer episodes of care, and services will need to be funded accordingly. Reports and deliverables should also incorporate details of older clients and the extent to which current services cater for the needs of this group.

3. Workforce development (WFD)

AOD services should ensure that appropriate WFD responses are provided to upskill workers. This includes incorporating relevant clinical supervision components and other forms of support for workers who will be increasingly dealing with clients from older age groups.

4. Service provision

Many services will need to undergo a degree of service redesign to ensure that older client populations are appropriately supported and cared for. This will be essential to ensure high quality, appropriate and sensitive services are provided to this group.

The next section of this guide provides examples of ways in which services may be better tailored to meet the needs of older clients.

Some of these examples may be readily adopted and modified in a range of different services. In other instances, a service may need to address their local and specific needs in a manner that best reflects their particular circumstances. In either instance, it is crucially important that all agencies provide close and careful consideration to the ways in which services can be improved to cater for the growing needs of this important segment of the community.

PART 3:

THE OLDER WISER LIFESTYLES (OWL) PROGRAM

AUSTRALIA'S FIRST OLDER PERSON-SPECIFIC AOD PROGRAM

Summary

The Older Wiser Lifestyles (OWL) Program was developed by Peninsula Health, Victoria as an age-specific best practice service model to address alcohol- and other drug-related harm among older adults.

The program has two distinct arms: early intervention (OWL-EI) and treatment (OWL-TR) which are underpinned by five core elements:

- Comprehensive screening and / or assessment
- Engagement
- Harm reduction strategies
- Office-based and outreach support
- Evidence-driven best practice.

The main referral sources for the OWL program are:

- Self-referrals
- Health organisations
- Allied health programs.

Based on the Florida BRITE project, OWL-EI identifies older adults at risk of experiencing AOD-related harm and provides age-specific early interventions. It offers a stepped care intervention tailored to the client's readiness to change and can be used with older adults within a range of specialist and non-specialist community health settings.

OWL-TR identifies older individuals who are currently drinking or using drugs at harmful levels or experiencing related problems. It involves a holistic assessment and intensive client-centred counselling, and can be used in a range of specialist alcohol and other drug settings.

Promotional activities among service providers and the broader community are critical to the success of OWL as they raise awareness and encourage access to the program.

The OWL program has developed a number of resources including:

- An information pamphlet for dissemination throughout the community
- The A-ARPS screening tool
- An OWL DVD.

3.1 What is the OWL program?

3.1.1 How was OWL developed?

The Older Wiser Lifestyles (OWL) Program was developed by Peninsula Health as a unique age-specific best practice service model to address alcohol- and other drug-related harm among older adults.

In 2007, Peninsula Health identified a gap in services for older adult-specific AOD treatment. Older people are under-represented in AOD treatment. Physiological changes and increased isolation put older people at increased risk of developing substance use issues. They are particularly vulnerable to the deleterious effects of substance use. Academic literature recommends developing older person-specific treatment options.

In 2008, Peninsula Health appointed the first older adult age-specific AOD clinician to develop an older person program. In 2009, funding was received from the Victorian Department of Health to appoint a specialised older adults psychologist, and develop OWL-Early Intervention (OWL-EI) with the aim of reducing risky drinking.

In 2010, Peninsula Health received a grant from St John of God to fund a nursing position to add to the team.

Currently the OWL program is comprised of a multidisciplinary team that has overcome barriers and built strong linkages with key stakeholders such as Aged Persons Mental Health and Aged Care services and local GPs.

3.1.2 Principles

The OWL program is underpinned by health promotion and harm minimisation principles and is designed to respond to the needs of a diverse client group. The program has two distinct arms: early intervention and treatment.

Both arms are underpinned by five core elements:

- Comprehensive screening and / or assessment
- Engagement
- Harm reduction strategies
- Office-based and outreach support
- Evidence-driven best practice.

3.1.3 Consumer consultation

Consistent with Peninsula Health's strong commitment to community participation, during the development of the OWL program consultation was undertaken with both the Older Persons' Community Advisory Group and the Alcohol and Drug Community Advisory Group. Both groups have been supportive of the OWL program and its direction.

3.1.4 Community consultation

Establishing and maintaining effective and meaningful partnerships with services and organisations in the broader community is a key priority for the OWL program. In the developmental stage of the OWL program a partnership was established with the Peninsula General Practice Network in order to disseminate information relating to the program and AOD issues faced by older adults.

Posters and brochures were designed using marketing images appropriate to older adults and disseminated by targeting locations that older adults are likely to attend. More recently the OWL program has partnered with the Frankston and Mornington Peninsula Medicare Local to distribute the Older and Wiser DVD.

3.1.5 Effective leadership

Prior to the establishment of OWL, few efforts had been made to increase older Australians' awareness of the risk of alcohol- and other drug-related harm. Through advocacy, research, evaluation, education and effective leadership, OWL has increased awareness and understanding of these harms to older adults, including the provision of assertive engagement and education to identified 'at-risk communities'.

In developing and disseminating Australia's first older adult-specific early intervention for alcohol- and drug-related harm, OWL has led and achieved much at a local, regional, statewide, federal and international level, including:

- Establishment of a peer-led screening program within Frankston Hospital
- Using iPads to access the screening
- Raising alcohol use among older adults as a priority area for response
- Facilitating training for health care workers, including GPs and HACC workers
- Improving referral and healthcare pathways based upon evidence gleaned from OWL.

In 2012, the OWL program was recognised nationally as a finalist in the Australian Alcohol and other Drug Awards. The Program has been a leading voice regarding AOD and older adults with a number of peer-reviewed and professional papers published both nationally and internationally (e.g., Bright, 2011; Bright et al., 2013). It has received national and international media coverage. At one point, more than 150 Australians accessed the OWL screening tool in a 24 hour period. OWL staff present at national and international conferences and collaborate with international experts, including the University of Southern Florida and the University of California, Los Angeles.

In November 2012, OWL developed and facilitated a national training program for GPs and other healthcare providers and continues to provide training programs as well as secondary consultations.

3.1.6 How effective is the program?

An independent evaluation of OWL was undertaken in 2013 and showed it to be a well-received and effective program:

- On the whole there was support for the effectiveness of the service model
- The program provided a broad range of interventions in response to the various needs of older adults
- Clients benefited from their experience with OWL and reported high satisfaction with the service
- Positive changes in drinking behaviour were observed among participants
- There were noticeable improvements in participants' physical and mental health
- Clients attributed changes in their drinking behaviour and health status to the information and education they received from the program
- The outreach mode of service delivery and aftercare were identified as key strengths of the program.

3.2 OWL Early Intervention (OWL-EI)

3.2.1 What is OWL-EI?

OWL Early Intervention (OWL-EI) is designed to identify older adults who are at risk of experiencing AOD-related harm and to provide an age-specific early intervention. OWL-EI draws from, and extends, the Florida BRITE project, adapted for the Australian context.

The Florida Brief Intervention Treatment for Elders (BRITE) Project offered brief intervention of one to five sessions to address substance use among older adults. A significant reduction in participants' SMAST-G scores was observed from baseline to discharge, and maintained at a 30 day follow up (Schonfeld et al., 2010).

OWL-EI offers a stepped care intervention tailored to the client's readiness to change. It is framed as a modulated program with interventions ranging from information, education and brief motivational intervention. Clients are initially expected to attend one to two sessions, however further contacts are scheduled as needed.

Readiness to change is measured using the Transtheoretical Model (TTM) of behaviour change (Prochaska, 1991; Prochaska, DiClemente, & Norcross, 1992; Prochaska & Velicer, 1997). The transtheoretical model outlines five stages of readiness to change (see Fig. 15, p47). Movement through each stage of change is not necessarily linear and typically progresses as follows:

1. *Pre-contemplation*: not thinking about change
2. *Contemplation*: beginning to recognise possibility of change but ambivalent about change
3. *Preparation*: committed to change, but not yet taking action

4. *Action*: making concrete changes
5. *Maintenance*: successfully changed her or his behaviour for a substantial period of time.

The content of the OWL-EI program is matched to the client's readiness to change based on the transtheoretical model.

3.2.2 Why brief intervention?

To effectively reduce alcohol- and other drug-related harm, it is essential to develop interventions that target the large population of individuals drinking at high levels, and not only those individuals who are dependent or problematic drinkers. There is extensive evidence that brief interventions are effective in reducing risky alcohol and other drug consumption and related harms (Kaner et al., 2007; Miller & Hester, 2003). Effective brief interventions range from five minutes of advice suitable for the primary care setting ('minimal intervention') to six sessions of counselling that can be delivered within alcohol and other drug settings ('brief therapy').

3.2.3 Who is OWL-EI for?

OWL-EI is designed to be used with older adults within a range of specialist and non-specialist community health settings that respond to people who use alcohol or other drugs, inclusive of misuse of prescription medications and OTC medications.

OWL-EI Case Study

Bob is a 74 year old retired, married male with a 12 year diagnosis of depression which he started to experience after he retired. He was referred to OWL by his GP who expressed concerns to him about a fatty liver. His wife also wanted him to enjoy more activities. Bob met with the OWL nurse and undertook the A-ARPS (Australian Alcohol-Related Problem Survey). Bob's AOD use was assessed as "harmful" due to the combination of his antidepressant medication and alcohol use, which he reported had increased from "a couple of stubbies" to about 4 stubbies of full strength beer daily.

Bob was motivated to change as he wanted to enjoy his retirement, be healthy and improve his relationship with his wife. He engaged in 6 sessions with the OWL nurse. Sessions covered psycho-education regarding the impacts of alcohol on depression, medication interactions and standard drinks, as well as counselling to manage his moods. Bob was supported to significantly reduce his alcohol use, develop meaningful activities and set achievable goals to improve the quality of his life.

3.3 OWL Treatment (OWL-TR)

3.3.1 What is OWL-TR?

OWL Treatment is aimed at identifying individuals aged 60 years and over in the community who are currently drinking or using drugs at harmful levels or experiencing problems with their alcohol or other drug use. The treatment arm of OWL offers holistic assessment and intensive client-centred counselling.

3.3.2 Why OWL-TR?

As discussed in Part 2, the terms ‘early onset’ (survivors), ‘late onset’ (reactors) and ‘maintainers’ are often used to describe the drinking behaviour of older adults. These terms reflect the age at which a person starts to experience alcohol-related problems. Typically, early onset drinkers have had a long history of harmful drinking, spanning early to late adulthood, whereas late onset drinkers started experiencing alcohol-related problems later in life.

In general, late onset drinkers appear ‘psychologically and physically healthier’, and tend to be more amenable to treatment compared with early onset drinkers (Atkinson & Misra, 2002). It is estimated that one-third of older adults experiencing alcohol problems may be late onset drinkers (Liberto, Oslin, & Ruskin, 1992; Sorocco & Ferrell, 2006).

A number of risk factors have been identified for AOD problems among older people, which have implications for treatment, including:

- Gender: older men are much more likely than older women to have alcohol-related problems (Myers et al., 1984)
- Loss of spouse: Hazardous drinking is more common among divorced or separated older adults and widowed men (Bucholz et al., 1995 cited in Substance Abuse and Mental Health Services Administration, 1998)
- Other losses: As people age, major life transitions are associated with significant loss for many older adults, including diminished income, self-esteem, purpose, social support networks, mobility and sense of independence, capacity to use or access public transport, and physical health (Substance Abuse and Mental Health Services Administration, 1998)
- Comorbid psychiatric disorders: Mood disorders may be either precipitating or maintenance factors associated with late onset drinking. Depression, for example, appears to precipitate drinking, particularly among women (Dupree, Broskowski, & Schonfeld, 1984)
- Family history of alcohol problems: There may be a greater genetic aetiology of problem drinking in early onset than in late onset male alcohol abusers (Atkinson, Tolson, & Turner, 1990)
- Concomitant substance use: Older adults who misuse alcohol tend to also use nicotine and misuse prescription drugs more than those who do not misuse alcohol (Goldberg, Burchfiel, Reed, Wergowske, & Chiu, 1994).

Given the range of risk factors, significant life transitions, and often minimal contact with services by older adults, it is critical to develop services that are responsive to the needs of older people.

3.3.3 Who is OWL-TR for?

OWL-TR is designed to be used with older adults in a range of specialist alcohol and other drug settings. Older adults are at increased risk of alcohol- and other drug-related harm because of the biological changes that occur as part of the ageing process, the interaction of AOD with medications, and the role these substances can play in the aetiology, exacerbation, and perpetuation of medical conditions.

OWL-TR Case Study

Mary presented as a 63 year old female, referred by Complex Care, with a 40-year history of alcohol and cannabis problems and mental illness due to childhood trauma and abuse. She currently lives alone with her dog and reports to be consuming 2-3 litres of white wine and smoking 1-2 grams of cannabis daily. Mary immigrated to Australia from Switzerland 13 years ago. She states she was sober for 12 years prior to her immigration but resumed drinking and using upon arrival due to loneliness and separation from family. Mary also advised she suffers from agoraphobia, major depressive disorder, anxiety and borderline personality disorder. She also has several health concerns after experiencing a bad fall previously this year. Mary reports she is prescribed several medications for pain and sleep and is compliant.

The OWL clinician conducted sessions in Mary's home where she was assessed and entered into the OWL program. A treatment plan was developed to include: alcohol and cannabis use reduction with a goal of abstinence; education regarding medication and AOD; individual counselling; coping skills development; exposure therapy; and support. The Mental Illness Fellowship, her general practitioner and a physiotherapist provided Mary with additional support.

Mary had insight into underlying issues yet she struggled with lack of motivation to reduce her alcohol and cannabis use. After four months of weekly counselling sessions she agreed to enter residential rehabilitation. Mary was supported by the OWL clinician through her admission and remained in the clinic for 40 days. Upon discharge from rehabilitation, Mary was slowly getting out of the house, walking her dog, attending the neighborhood community centre and starting to build a network of friends. She is remaining abstinent and reports she is feeling better emotionally and physically. Mary has remained engaged with OWL for relapse prevention strategies.

3.3.4 Treatment Tips from the OWL Clinicians

Respect

Understand that the person with whom you are speaking has lived many years and their life experience, strengths and personal history are valuable. Acknowledging this will assist particularly if the individual is losing or has lost hope.

Patience

Anecdotal evidence demonstrates that the old adage “you can’t teach an old dog new tricks” is a myth. Older adults can indeed change their habits, but may take longer in doing so. Some older adults may repeat themselves or have poor short-term memory, and session content may have to be reiterated a few times before it is absorbed.

Rapport

It is important to build rapport to foster and enhance trust. Find an age-relevant topic to discuss (e.g., interests, hobbies, grandchildren, gardening, book clubs, etc.). You do not need to be older to work with older adults; you just need empathy and an ability to relate.

Approach

Choose your words carefully when approaching the subjects of alcohol and other drug use. You will get a more honest and accurate answer if you are non-judgemental and casual. For example, ask: “Do you enjoy a drink?” as opposed to “Are you concerned about your drinking?” or “Do you think you have a problem?”

Flexibility

Older adults are not all the same and will require a wide variety of interventions depending on their individual presentations and goals. Be willing to adjust goals as they may tend to change depending on the client’s current motivation and abilities.

Boundaries

Sometimes you are the only contact in a person’s life. Depending on your client’s situation they may be experiencing loneliness and isolation. This could potentially create significant dependency on you, so it is always best to be clear about what your role is and the client’s expectations of your involvement.

Thoroughness

Be as thorough as possible when assessing an older adult, ensuring you gather information regarding their mental and physical health as well as social and familial influences.

Awareness

Have a good understanding of the variety of issues that are unique to this stage of life. This may include: retirement, identity and role changes, bereavement, loneliness, isolation and stigma just to name a few. Also be aware of your own beliefs and values regarding the ageing process and reflect on how these beliefs could impact on your perception of the client and your subsequent interactions.

3.4 Promotional and networking activities and resources

Promotional activities are critical to the success of OWL. Older risky drinkers and drug users can be a hidden population and proactive strategies are essential for engagement. Promotional activities serve three key purposes:

- Raising awareness of the program among older adults and the broader community
- Educating older adults about AOD-related health risks
- Facilitating access to the program.

Promotional activities include:

- Community-based talks (e.g., in nursing homes, retirement villages, ProBUS clubs, Rotary clubs, community groups)
- Media releases, articles and events
- Stands at public events (e.g., Annual Ageing Well Expos)
- In-service training and site visits (e.g., GP clinics, staff training sessions within Peninsula Health).

3.5 OWL resources

As part of the development of the OWL program the following resources have been developed:

OWL information pamphlet: for dissemination throughout the community.

A-ARPS screening tool: A partnership was established with the developers of the Alcohol-Related Problems Survey (ARPS) at The University of California, Los Angeles. The ARPS is a computerised screening tool that assesses clients' risk of experiencing alcohol-related harm using 176 algorithms. These algorithms consider medical history, prescription and OTC medication use and activities of daily living. As there is a 40% difference in what constitutes a standard drink in Australia compared with the USA, the ARPS was first recalibrated to ensure that it would be valid to use in Australia. There is no other equivalent tool in Australia. The Australian ARPS (A-ARPS) is now freely available for use and is valid across all Australian jurisdictions (see www.wisedrinking.org).

OWL DVD: Through a partnership with Casuarina Media and a steering committee of older consumers, the OWL team developed an educational DVD resource targeting older adults and health professionals. It aims to raise awareness of the risks associated with alcohol use and provide skill development opportunities for health professionals. The Older and Wiser DVD is a 20 minute film told through three entwining stories and interspersed with professional commentary. The DVD includes: Older and Wiser, Older and Wiser with professional commentary, 10 minute commentary for health practitioners, 10 minute meditation exercise and a 20 minute Radio National interview on the Older Wiser Lifestyles program.

3.6 Community awareness

Awareness generates concern and curiosity and that leads to self-referrals

Many older adults are unaware of the impact that ageing can have on their risk of experiencing alcohol-related harm. Prior to the establishment of the OWL team there had been little effort within Australia to increase older adults' awareness of these issues. The OWL team has enhanced awareness in the local community through the delivery of community education in a variety of contexts, including: aged care facilities, ageing well expos, dementia awareness days, Probus clubs, rehabilitation programs, retirement villages and seniors' clubs.

Community presentations and media activities are an effective way of raising awareness of AOD-related health issues and generating referrals. During the evaluation of the OWL Program, one key referrer associated a peak in referrals with 'workers being out and about in the community spreading the word'.

Activities such as presentations can provide 'teachable moments' for older adults who may not otherwise receive information about alcohol-related health issues such as the interaction between alcohol and medications.

Promotional material focusing on older adult specific health concerns, such as dementia, tend to yield more interest than messages about alcohol-related health issues. This illustrates the importance of tailoring health messages to the target audience and being aware of the stigma often associated with alcohol and other drug use.

It was easy to discuss things with [the OWL worker] and she listened to what I had to say. It was good to speak to someone who knew about medications and different health problems.

I was embarrassed to admit I had a drinking problem but [the OWL worker] was very knowledgeable and non-judgmental.

3.7 Service sector awareness

The broader health service sector may be a more difficult audience to engage than the older people themselves. Delivering presentations to staff and conducting in-service training sessions within health services can raise awareness of the program. Age-specific services, such as aged care and retirement homes, are receptive services for OWL. Relationships and referral networks need to be maintained through regular and ongoing communication with the service sector, including GPs and other primary and community health providers.

Key referrers to the OWL program have described OWL community presentations and media activities as effective in raising awareness of alcohol-related health issues and generating referrals.

OWL Promotional activities study

Alice is a 67 year old retired female who attended a Cardiac Rehab group. She listened to an informative session that educated her regarding the physiological changes that happen as we age, interactions between alcohol and medications, and gave a demonstration of what a standard drink is.

Alice stated that she was never aware of this and will now measure and limit her drinks as she does enjoy a glass of wine most evenings. She will also discuss what is considered safe for her with her GP.

3.8 Referral pathways

3.8.1 What are the main referral pathways?

The main referral sources for the OWL program are likely to be:

- Self-referrals (e.g., older people registering interest in the program directly)
- Health organisations' centralised intake services
- Allied health programs (e.g., occupational therapist, physiotherapist, dietician).

The initial information point often differs for EI and treatment clients. For example, EI clients typically self-refer in response to attending a health awareness raising presentation delivered by OWL staff, whereas treatment clients may learn about OWL via speaking with a health practitioner (e.g., nurse) about their AOD use.

3.8.2 How are referrals facilitated?

Risky or dependent AOD use by older adults is typically identified via standard screens or through conversations with patients about other health or lifestyle issues such as poor sleep patterns, medications or grief. This suggests that potential referrers need to be provided with training and ongoing information about the program in order to facilitate referrals.

Factors facilitating the referral process are:

- A clear understanding of the program by referrers through in-service training and ongoing contact with OWL
- Access to information about OWL (i.e., pamphlets)
- Timely response to referrals
- Direct contact with OWL staff either via the telephone or in person.

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