Alcohol and Drug Foundation

Older adults, alcohol and other drugs.

Summary report

VICTORIA State Government

adf.org.au

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Data source

Data used in this report were extracted by NDARC from the following data collections:

- Cause of Death Unit Record File (CODURF)
- National Hospital Morbidity Database (NHMD)
- Alcohol and Other Drug Treatment Services National Minimum Data Set (AODTS NMDS)
- National Drug Strategy Household Survey (NDSHS).

For NDARC published research reports, visit:
Substance Use and Related Harms Among Australians Aged ≥50 years 2001-2021
Strategies to reduce AOD-related harms among older adults

Date published: October 2024

Contents

Note: throughout this document the common sector acronym 'AOD' is used as an alternative to the phrase 'alcohol and other drugs'.

Executive summary

About the ADF

The Alcohol and Drug Foundation (ADF) is Australia's leading organisation committed to inspiring positive change and delivering evidence-based approaches to minimise alcohol and other drug (AOD) harm. As an evidence-based organisation, the ADF has a key strategic focus on 'knowing what works' and aims to build the knowledge base and understanding of effective AOD harm minimisation policies and programs.

About this research project

The ADF undertook an in-depth research project to better understand national trends in AOD-related harms among older adults (aged 50 and above) and identify effective evidence-based harm minimisation approaches that could be tailored for this age group. This work was funded by the Department of Health, Victoria.

Snapshot findings: Identified groups at risk and risk factors

- **Groups at higher risk of AOD-related harm:**
  - men
  - 50-59 year olds.
- **Substances linked to greater risk of harm:**
  - alcohol
  - opioids
  - benzodiazepines (and related medications).
- **Other identified risk factors in AOD-related harms:**
  - using drugs at home alone
  - living remotely or rurally
  - polysubstance/pharmacy use
  - psychosocial risk factors (such as limited ability to work, socialise, exercise or engage in activities due to disability, experiences of mental ill health, loss of family supports or relationships, and unemployment).

Snapshot findings: Minimising AOD harm

Information sources and delivery

- Health practitioners are the preferred source of AOD information among older adults. Ensuring practitioners have the necessary resources, capacity, and skills to identify older adults' risky AOD use, and direct them to appropriate support and information resources may help minimise harms.
- Older adults may also value receiving information through their social peer networks.

Information content

- Content should be accessible and be conveyed in different formats.
- Improving health literacy may support information and help seeking.
- Information about the planned reduction, or stopping, of prescription medicines should include details of side-effects, as some older adults said they would be better motivated by understanding the risk of side effects.
- Alcohol-related content should focus on protecting existing health, clearly communicate the evidence around alcohol, and recognise the social role alcohol plays in many older adults' lives.

Interventions

- Alcohol-related interventions should provide information in multiple ways, for example written content alongside audio and/or visual information.
- Improving social connectedness may be effective in reducing alcohol-related harms, including via more non-alcohol related social activities.
- Patient empowerment models are potentially beneficial interventions for stopping benzodiazepine and related medication use, such as EMPOWER (Eliminating Medications Through Patient Ownership of End Results).

- Other considerations when developing interventions:
  - Overdose awareness and prevention interventions are needed, particularly around opioids and benzodiazepines.
  - AOD interventions may benefit from taking a more holistic view of older adults, including mental health and disability.
  - Risks around polypharmacy use (use of more than one medication) should be clearly communicated to older adults when prescribed, and take-home naloxone considered when opioids are prescribed.
  - Remote and very remote areas need greater investment in resources and interventions to reduce harms.

Gaps and future directions

- There is a substantial lack of research around older adults and other drugs, including amphetamines and cannabis.
- Australia's ageing population, and the growth in the number and proportion of older people, highlights the need for further research and evaluation, particularly on harm reduction messaging and interventions.[1]
- Evaluation of interventions for older adults aged 50-59 is needed.
- Future research may benefit from focusing on sub-populations of older adults who may experience higher rates of AOD use and related harms, including people who identify as LGBTIQA+, Aboriginal or Torres Strait Islander and migrant and multicultural communities.
- Comprehensive evidence-based interventions that address some of the social determinants of AOD-related harms in older adults have the potential to help older adults to continue to age well and reduce the burden on service demand.

Why we did the research

Australia has an ageing population, and the number and proportion of older people is growing.

In 2021, Australians aged 50 and above made up over a third (35%) of the national population.[1]

Older adults are a diverse group, with varied ages, life experiences and backgrounds which affect both the ageing process and individual health and wellbeing.[2]

Many older adults have an increased risk of certain AOD-related harms. Changes in physical and mental wellbeing, feelings of isolation and the increased likelihood of being prescribed medication and using multiple medications, all contribute to the risk of harm.[3]

As a part of the ageing process, older adults can also become more sensitive to alcohol, increasing the risk of falls, bone fractures, and other injuries.[4]

Recent data from the Australian National Drug Strategy Household Survey (NDSHS) show that the proportion of people who drink daily increases with age.[5]

In 2022-23, those aged 70 and over continued to be the most likely to drink daily (11.7%), followed by people in their 60s (8.5%) and 50s (6.5%).[5]

The latest NDSHS also indicated that there is an ageing group of Australians using illicit drugs, with shifting rates of use compared to previous years.[5]

Among those aged in their 50s, recent use of any illicit drug nearly doubled between 2001 (6.7%) and 2022-23 (13.6%), while the proportion of people aged 60 or above who had ever used illicit drugs rose from 29% in 2019, to 34% in 2022–23.[5]

Some older adults experience higher rates of AOD-related harms than others, so there is a need for tailored messaging and interventions to reduce and prevent harms for these sub-groups.

This research will inform a greater understanding of what works to prevent and minimise harms experienced by older adults; where efforts should be directed; and, where gaps in research exist that need to be addressed.

How we did the research

The ADF engaged NDARC as our research project partner. Together, we developed an analysis report which includes:

- data and trends in AOD-related hospitalisations, deaths, treatment episodes and past year use among older Australians
- identification of older adult sub-groups at higher risk, as well as risk factors.

A rapid review of evidence-based approaches to minimise AOD-related harm among older adults was also undertaken to identify:

- preferred information and information sources
- effective interventions
- any gaps and areas for future research.

The research findings were used to develop recommendations for minimising AOD-related harm among older Australians.

This report provides a summary of the findings from the research project. For further information and full reports, visit the NDARC website.

What we found: Trends in AOD use and related harms

AOD use, 2022-23

The most common substances used were alcohol (77%), cannabis (5.4%), pain killers/pain relievers (2.1%) and tranquilisers/sleeping pills for non-medical purposes (1.3%).

Risky drinking

The latest NDSHS highlights risky drinking patterns among some older Australians:

- 1 in 3 people (33%) aged 60 to 69 drank alcohol at risky levels. This is similar to the proportion of people in their late 20s through to people in their 50s (32%).
- People aged 70 and over had the lowest proportion of risky drinking of all adult age groups (25%).
- Older adults in their 60s and 70s remained just as likely to drink in risky ways in 2022-23 as 12 years ago, but the proportion of people aged 50-59 drinking at risky levels has decreased slightly, from 36% in 2010 to 32% in 2022-23.
- Males aged 60-69 had a higher proportion of risky drinking, with 44% doing so, compared to 23% of females the same age.

Illicit drug use

The NDSHS 2022-23 also indicates that there is an ageing group of Australians using illicit drugs, with shifting rates of use compared to previous years:

- Between 2001 and 2022–23, use of any illicit drug in the past year has nearly doubled among people in their 50s (from 6.7% to 13.6%), with similar increases for both males (from 8.1% to 16.1%) and females (5.2% to 11%).
- Past year illicit drug use has also increased in those aged 60 and over, from 3.9% in 2001 to 7.8% in 2022–23.
- The most commonly used illicit drug by older people is cannabis.[6]

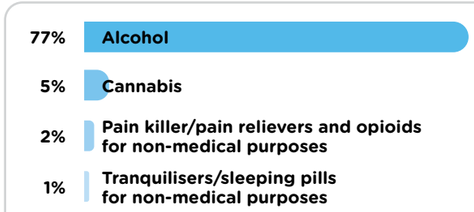
Use of medications

Data from the Pharmaceutical Benefits Scheme (PBS) indicate that rates of dispensing opioids and benzodiazepines increase with age and are highest for people over 60 years.[6]

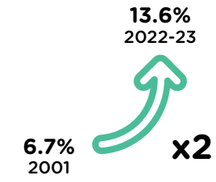
In 2021–22:

- People aged 80 and over had the highest rates of scripts dispensed of any age group for opioids and benzodiazepines, followed by people aged 70–79, 60–69 and 50–59.
- Among people aged 80 and over, the rate of scripts dispensed for opioids was at least twice as high as people in younger age groups.[6]
- Females aged 80 and over had the highest dispensing rates of any group for opioids and benzodiazepines.
- In 2022–23, 4% of people in their 50s and 3.7% of people aged 60 and over reported recent use of a pharmaceutical for non-medical purposes, compared with 5.3% of all people aged 14 and over.

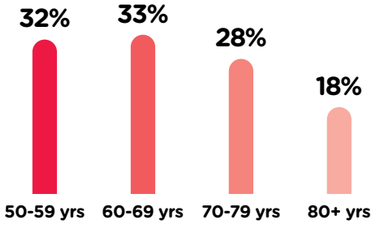
Trends in AOD use



Alcohol was the most common substance used in the past year

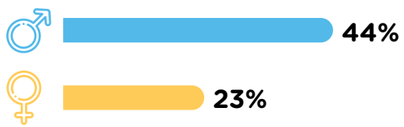


Use of any illicit drug has nearly doubled in people in their 50s



Around 1 in 3 older Australians are drinking alcohol at risky levels

Cannabis is the most commonly used illicit drug for older people



Risky drinking in men vs women aged 60-69

People aged 80+ highest rates of scripts for opioids and benzodiazepines

AOD-related hospitalisations, 2020-21

In 2020-21, there were 46,986 AOD-related hospitalisations among older adults in Australia – on average of 129 hospitalisations per day.

Age

- The rate of AOD-related hospitalisations among older adults was slightly lower than that of Australians of all ages (525.5 hospitalisations per 100,000 people, compared to 570.3).
- The highest rates of AOD-related hospitalisations among older adults were in those aged 50-59 (822.8 per 100,000 people), but rates have increased across all age groups over the past two decades.

Sex

- AOD-related hospitalisations among Australians aged 50 and above were more frequent for males than females (619.4 versus 439.0 per 100,000 people).

Remoteness

- AOD-related hospitalisations of older adults were more frequent in remote and very remote areas (860.1 per 100,000 people in 2020-21). This was driven by alcohol-related hospitalisations (763.3 per 100,000 people in 2020-21).
- Other drug-related hospitalisations are similar across locations, but slightly higher in major cities (115.1 per 100,000 people in 2020-21).

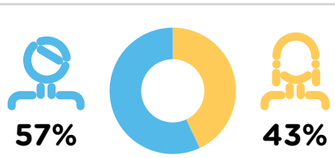
Overdose

- Less than 1% of alcohol-related hospitalisations were linked to overdose over the past decade.
- In 2020-21, 63% of other drug-related hospitalisations were attributable to overdose.

Drug type

- Most AOD-related hospitalisations were related to alcohol (79%), and this has remained consistent over the past decade.
- The largest increase in hospitalisations was observed for amphetamine-type stimulants, which was 13 times higher in 2020-21 (12.0 per 100,000 people) than in 2002-03 (0.9 per 100,000 people).

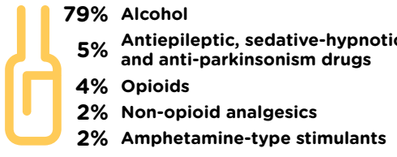
AOD-related hospitalisations among Australians aged ≥50 years



Approximately three in five hospitalisations occurred among males in 2020-2021

89% of AOD-related hospitalisations in rural and remote areas due to alcohol

Two-fifths of other drug hospitalisations were attributable to overdose in 2020-2021



The vast majority of all AOD-related hospitalisations were attributable to alcohol

AOD treatment, 2020-21

In 2020-21, there were 33,531 AOD treatment episodes among older adults in Australia (375 treatment episodes per 100,000 people).

The rate in 2020-21 was twice as high as 2002-03 (151.4 per 100,000 people) but remained lower than reported among Australians of all ages (486.1 treatment episodes per 100,000 people).

Age

- People aged 50-59 had the highest rate of treatment (759.7 per 100,000 people) of all older adults, but the rate of treatment episodes has more than doubled in all older adult age groups over the previous decade.

Sex

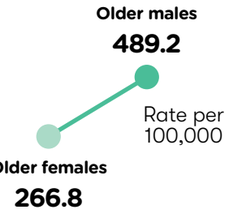
- AOD treatment episodes were twice as frequent among older males (489.2 per 100,000 people) than older females (266.8 per 100,000 people).

Remoteness

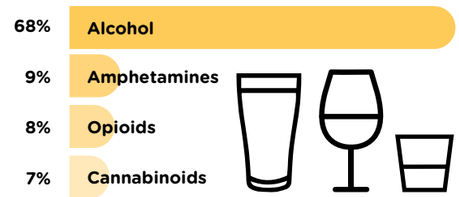
- The rate of treatment episodes is highest in remote and very remote areas, with the rate of treatment episodes in these areas more than doubling between 2001-02 (315.0 per 100,000 people) and 2020-21 (825.2 per 100,000 people).

Drug type

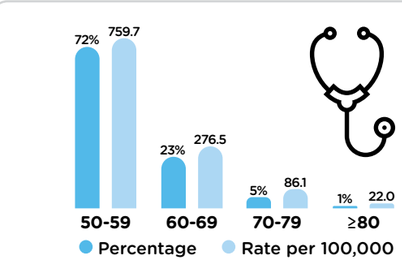
- Alcohol was the most common drug type (68% or 254.4 treatment episodes per 100,000 people), followed by amphetamines (9% or 33.1 treatment episodes per 100,000 people), and opioids (8% or 28.2 treatment episodes per 100,000 people).
- The rate of amphetamine-related treatment episodes was 23 times higher in 2020-21 (33.1 treatment episodes per 100,000 people), than 2002-03 (1.4 treatment episodes per 100,000 people).



Treatment episodes almost double in males than females



Alcohol was the most common drug that people were entering treatment for



Treatment episodes were most common among those aged 50-59 years

The rate of people entering treatment for amphetamines has increased 23-fold

AOD-induced deaths, 2021

In 2021, there were 1,933 alcohol and other drug induced deaths among older adults in Australia.

Sex

- The rate of AOD-induced deaths was more than twice as high among older males than older females (30.5 versus 13.5 per 100,000 people).

Age

- The rate of AOD-induced deaths among older adults was almost twice as high compared to Australians of all ages (21.6 deaths per 100,000 people, compared to 13.1).
- The rate of AOD-induced deaths among 50-59-year-olds increased significantly over the past two decades (18.7 in 2002 to 27.1 per 100,000 in 2021). It also increased slightly in those aged 80 and above (12.8 in 2002 to 15.5 per 100,000 in 2021).
- The rate slightly decreased for 60-69-year-olds (22.1 in 2001 to 21.8 per 100,000 people in 2021) and 70-79-year-olds (17.2 in 2001 to 15.8 in 2021 per 100,00 people).

Remoteness

- The highest rates of alcohol-induced deaths among older adults occurred in remote and very remote areas (20.0 per 100,000 people in 2021).
- The rate of drug-induced deaths was higher in major cities (8.9 per 100,000 people in 2020-21).

Cause

- Only 6.2% of all alcohol-induced deaths were due to overdose, with most deaths the result of other causes (largely cardiovascular, digestive and endocrine diseases).
- The majority (95%) of other drug-induced deaths were due to overdose, with 61% of all AOD-induced overdose deaths unintentional.
- Opioids (such as heroin and pharmaceutical opioids) and antiepileptic, sedative-hypnotic and anti-parkinsonism drugs (such as benzodiazepines), were the most common drug types involved in drug overdose deaths.
- Around two-thirds (63%) of AOD-induced overdose deaths in older adults involved more than one drug type, with the most common being opioids and antiepileptic, sedative-hypnotic and anti-parkinsonism drugs.

Risk factors

The issue of drug-induced deaths is complex, with factors such as socio-economic disadvantage, mental health, and lack of access to healthcare and harm reduction services playing a key role.

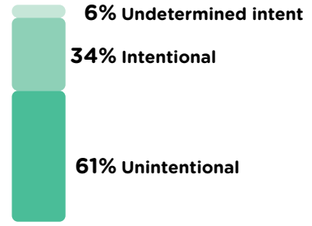
The most common psychosocial risk factors identified in AOD-induced deaths among older Australians between 2017-22, were:

- personal history of self-harm (12%)
- limitations of activities due to disability (7%)
- disappearance or death of a family member (7%).

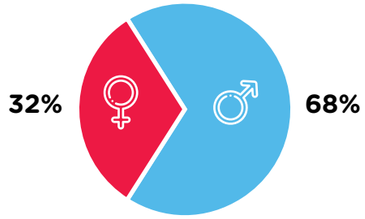
Psychosocial risk factors were more commonly identified in intentional drug overdose deaths, rather than unintentional (72% versus 27%).

Trends in AOD-induced deaths

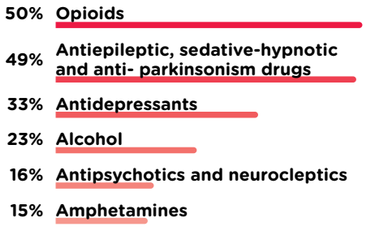
AOD-induced deaths among Australians aged ≥50 years have increased slightly



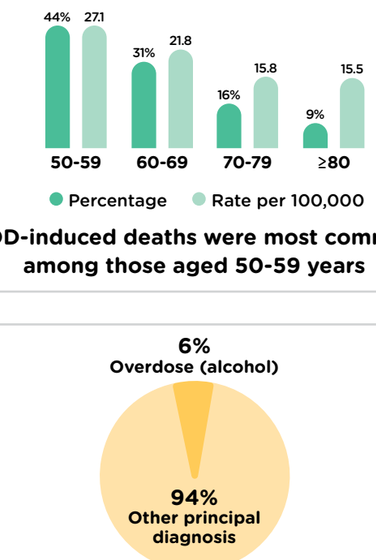
In 2021, most overdose deaths were unintentional



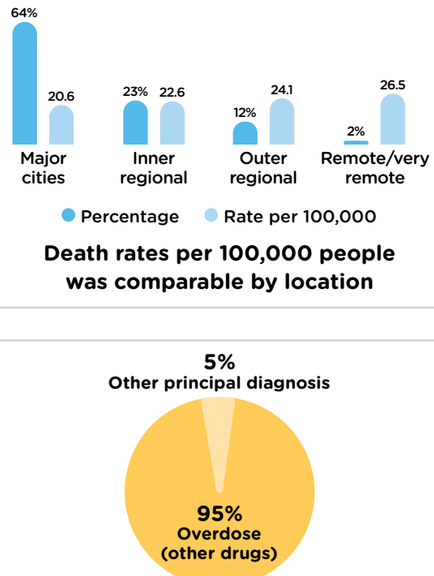
Approximately two in three deaths were male



The most common drug types involved in drug overdose deaths



AOD-induced deaths were most common among those aged 50-59 years



Death rates per 100,000 people was comparable by location

Few alcohol-related deaths were attributable to overdose in 2021

The majority of other drug-related deaths were attributable to overdose

AOD harms: Groups at risk, substances, and risk factors

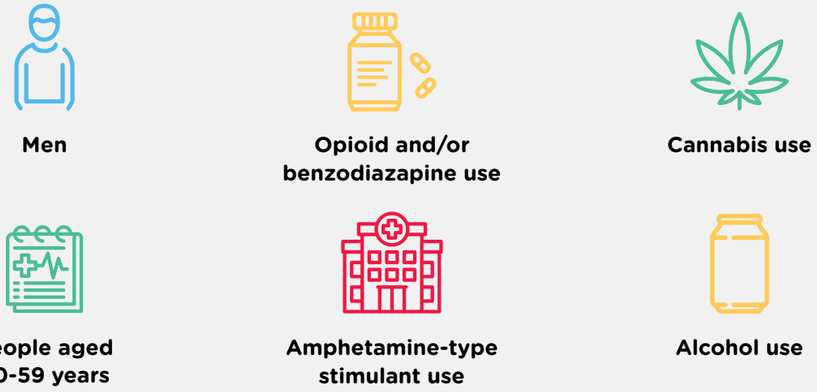
Some older Australians experience greater risk of AOD-related harm than others, including:

- **Older men**
  - Older males have overall higher rates of AOD-induced deaths, AOD-related hospitalisations, and AOD treatment episodes, compared to older females.
- **Older adults aged 50-59**
  - People aged 50-59 consistently had higher rates of AOD-related harms, compared to those aged 60 and above, including hospitalisations (except for unintentional hospitalisations due to overdose, where rates were highest among people aged 70+), deaths and treatment.

Some substances were linked to higher risk of harms among older adults, including:

- **Alcohol**
  - Most AOD-related hospitalisations were attributable to alcohol (79%), with the rate of alcohol-related hospitalisations almost 4 times higher than all other drug-related hospitalisations combined.
  - The most common principal diagnosis for alcohol-related hospitalisations was dependence (182.4 per 100,000 people), followed by cardiovascular, digestive and endocrine diseases (79.5 per 100,000 people) and acute intoxication (62.1 per 100,000 people).
  - Hospitalisation due to harmful alcohol use has increased more than five-fold from 2002-03 (8.5 to 46.7 per 100,000 people in 2020-21).
  - Alcohol was the principal drug of concern for most (68%) AOD treatment episodes among older adults.
  - Around 1 in 3 older adults reported risky drinking in the past year (i.e. consuming more than 10 standard drinks per week and more than 4 standard drinks on any single day). This was highest among those aged 50-59 (32%) and 60-69 (33%).
- **Opioids and/or benzodiazepines**
  - Overdose deaths were related to opioids (26%, equating to 399 deaths, or 4.5 deaths per 100,000 people), and antiepileptic, sedative-hypnotic and anti-parkinsonism drugs (26%, equating to 392 deaths or 4.4 deaths per 100,000 people). The most common opioid involved were natural and semi-synthetic opioids (e.g. oxycodone).
  - The rate of drug overdose deaths involving opioids and antiepileptic, sedative-hypnotic and anti-parkinsonism drugs was highest among the 50-59 age group. However, in 2021 there were notable increases in deaths involving the same drugs among the 80+ age group (3.5 and 4.4 per 100,000 people respectively).
- **Amphetamine-type stimulants**
  - There have been significant increases in hospitalisations, treatment episodes and overdose deaths for amphetamine-type stimulants over the past decade. Specifically, both drug-related hospitalisations and drug-induced deaths with amphetamine-type stimulants as a principal diagnosis increased thirteen-fold, from 0.9 per 100,000 people (2002-03) to 12.0 per 100,000 people (2020-21), and from 0.09 per 100,000 people (2005) to 1.4 per 100.000 people (2021), respectively.
- **Cannabis**
  - Cannabis use has risen among older adults. While no increase in cannabinoid-related hospitalisations or deaths has been seen, the rate of treatment episodes for cannabis was 5 times higher in 2020-21, compared to 2002-03.

Groups and substances most linked to AOD harms in older adults



Risk factors

Other risk factors identified in the analysis of AOD-related harms, include:

- **Using drugs at home, alone:**
  - overdose deaths were more likely to have occurred at home (79% in 2021).
- **Remoteness:**
  - Alcohol-related hospitalisations and alcohol-induced deaths were highest in remote and very remote areas.
  - The rate of treatment episodes has also consistently been highest in remote and very remote areas, doubling over the past decade.
- **Polysubstance use:**
  - In 2021, two-thirds of AOD-induced deaths involved more than one drug type.
- **Psychosocial risk factors:**
  - Among AOD overdose deaths between 2017-21, 39% of cases had a psychosocial risk factor involved. This varied between intentional and unintentional deaths, where psychosocial risk factors were recorded in 72% and 21% of cases, respectively.
  - Self-harm and limitations of activities due to disability were the most common risk factors identified in intentional overdose deaths, while self-harm, disappearance or death of a family member, and unemployment were the most common risk factors identified in unintentional overdose deaths.

What we found: Minimising AOD-related harms among older adults

Information

Ensuring older adults have accurate and accessible information relating to AOD risks can help minimise harms.

Our research identified preferred information sources and content based on findings from the available evidence. These are summarised below.

Preferred sources

- Healthcare providers are the preferred source of AOD information for older adults.
- Conversations between prescribers or pharmacists and older adults around AOD are most commonly about medications, less so about alcohol, and even less frequently about other drugs.
- Overall older adults would like longer, more in depth AOD conversations with prescribers.

Preferred content

- AOD materials for older adults would benefit from using larger text, featuring images of relatable older adults and providing optional translation and subtitles.
- Awareness of alcohol-related harms alone is unlikely to motivate older adults to change their drinking, as alcohol plays a social role in many older adults' lives.
- Motivations to reduce risky drinking may vary depending on the type of alcohol-related 'harm'. One study found most older drinkers would stick to low-risk guidelines if it was communicated that doing so could reduce their risk of dementia.
- Many older adults consider themselves to be responsible drinkers, and communications that recognise their perceived experience of drinking 'wisely' could be effective in engaging this group and delivering harm minimisation information.
- Information focusing on the risk of side effects when planning the reduction or cessation of medications for patients may be effective for some older adults.
- There was a lack of available evidence relating to content preferences on other drugs, excluding alcohol, opioids and benzodiazepines.

Interventions

Evaluation of AOD-related harm minimisation interventions for older adults varied but mostly comprised:

- brief interventions (e.g. educational tools/ leaflets, personalised reports, and alcohol and drug diaries)
- psychosocial interventions (e.g. cognitive behavioural therapy, mindfulness, exercise, social connectedness).

Key findings:

- Overall, there's a lack of recent, specific and consistent research on interventions to reduce AOD-related harms among older adults.
- There's some evidence supporting the effectiveness of brief interventions in minimising alcohol and benzodiazepine-related harms, but less relating to opioids, and a substantial lack for other drugs.

Interventions that included (but were not specific to) older adults suggest that there are three elements of effective alcohol interventions: the provision of information, personalised feedback, and being in contact with others.

Minimising AOD-related harms among older adults

Heathcare professionals are the preferred source of information

Knowledge of alcohol harms alone unlikely to change older adults from drinking

Consultations focus on medications, less on alcohol, even less on other drugs

Emphasis on 'drinking wisely' and maintaining existing wellbeing could be effective messaging

Older adults want longer, more in depth AOD conversations with prescribers

AOD materials could use large text, subtitles, relatable images

Patient empowerment appears to be effective in improving sedative-hypnotic/ benzodiazepines cessation

Brief interventions appear to be effective in reducing alcohol-related harms

Educational and psychological interventions may be effective in reducing opioid-related harms

Few interventions that were aimed at reducing harms of cannabis or illegal drugs

What works: Findings overview

Table 1 provides an overview of the evidence for information sources and content, interventions, and recommendations related to each drug area along with identified gaps within the evidence:

Alcohol

Information	Interventions	Recommendations and Gaps
Preferred sources: • Healthcare providers • Personal stories/lived experience **Preferred content:** • Accessible info (e.g. large font, optional translation, subtitles) • Age-appropriate people represented • Transparent information (e.g. how drinking guidelines were developed) • Multiple types of info: delivered verbally, along with written materials • Awareness of alcohol-related harms alone is unlikely to motivate changes in consumption, especially among those who consider themselves healthy	• Some evidence for the efficacy of brief interventions, and/or psychological treatments • Review of studies that included (but were not specific to) older adults found interventions were more effective when they involved: – information on several alcohol-related issues – personalised feedback about drinking behaviours – contact and communication with others about alcohol	**Recommendations:** • Training to ensure key healthcare providers are equipped to identify and intervene in risky drinking patterns • Promote social and leisure activities that don't involve alcohol • Messaging about protecting current level of health and wellbeing • Interventions that include educational information and personalised feedback • Future research on how social networks could contribute to a successful intervention **Gaps:** • Interventions in rural/remote areas, and among First Nations, CALD, LGBTIQA+ communities • Work-to-retirement interventions • Cognition or dementia-based outcomes • Australian studies

Benzodiazepines (and related medicines)

Information	Interventions	Recommendations and Gaps
Preferred sources: • Healthcare providers • Longer, more in depth and two-way conversations desired **Preferred content:** • Accessible information (e.g. large font, optional translation, subtitles) • Multiple types of information, delivered verbally, along with written materials • Clear, and comprehensive information • Reasons for reducing or stopping prescribed medications which focus on the risk of side effects	• Available evidence mostly on education-based interventions and cognitive behavioural therapy for insomnia (CBTi) • CBTi shows some effectiveness in treating sleep issues and reducing medication use among older adults • Patient empowerment interventions, in particular EMPOWER, show some effectiveness in ceasing use among older adults	**Recommendations:** • Prescribers should adapt communication based on patients' attitudes to medicines and preferences around involvement in the decision-making process • Programs to improve health literacy • Interventions may benefit from focusing on patient-empowerment models, such as EMPOWER **Gaps:** • Evidence for 'younger' older adults aged 50-70 • Under-representation of some populations • Interventions on overdose awareness and prevention • Australian data

Opioids

Information	Interventions	Recommendations and Gaps
Preferred sources: • Healthcare providers • Longer, more in depth and two-way conversations desired **Preferred content:** • Accessible info (e.g. large font, optional translation, subtitles) • Multiple types of info, delivered verbally, along with written materials • Clear, and comprehensive information	• Considerable variation in the types of interventions evaluated • Educational and psychological interventions showed some evidence of effectiveness (primarily the Mindfulness-Oriented Recovery Enhancement model) • Community pharmacies may be a valuable resource for identifying and reducing health harm in patients who use pharmaceutical opioids	**Recommendations:** • Prescribers should adapt communication based on patients' attitudes to medicines and preferences regarding involvement in the decision-making process • Programs to improve health literacy • Consider leveraging community pharmacies, and offering take-home naloxone **Gaps:** • Holistic interventions that consider impact of disability on quality of life • Evidence for 'older' older adults (aged 60+) • Effective strategies to limit illegal opioid use • Interventions on overdose awareness and prevention • Australian data

Other drugs

Information	Interventions	Recommendations and Gaps
Preferred sources: unknown **Preferred content:** unknown	• Near-total lack of available evidence in this area • Preliminary supportive data for combined therapies in older adults with HIV (CBT + tai chi + text message support)	**Gaps:** • Evident lack of research specific to illegal, or recently medicalised, substances (e.g. cannabis) • Evaluations of peer-delivered interventions • Under-researched populations common across substances: CALD, LGBTIQA+, First Nations • Australian data

Our recommendations

Our recommendations were developed following the analysis of AOD use and related harms among older Australians and a formal review of strategies to minimise such harms.

Information sources and delivery:

1. Increase key health practitioners' capacity to support older adults in reducing risky drinking:

- Health practitioners are a trusted source of information for older adults, but conversations about AOD use and related harms aren't very common. Addressing barriers and workforce development needs by ensuring key healthcare providers have the necessary resources and skills to identify and better support older adults to reduce risky drinking patterns is critical.
- While there are likely structural barriers to this (e.g. limited practitioner time), these gaps represent potential missed opportunities, particularly as this cohort is increasingly likely to present to health practitioners as they age.
- Practitioners, including pharmacists, GPs and other prescribers, should routinely discuss the interaction effects of medicines. Community pharmacies may be a valuable resource for identifying and reducing AOD-related harm in older adults.

2. Expand AOD information delivery via social peer networks:

- Some older adults may prefer and/or benefit from learning about peers' personal stories of recovery, and the expertise of older adults with lived and living experience of AOD-related harms.
- This could be delivered via existing social networks such as Men's Sheds, women's circles, seniors' centres, community centres, veterans' organisations, churches, and other cultural and social gathering locations.

Information content:

3. Improve AOD-related information by making content more accessible:

- Information should be easy to understand (e.g. use large font, optional translation, and subtitles).
- Information should be provided in a range of ways (such as written, visual and audio), and with varying levels of detail (simple, easy to understand information, alongside more detailed, comprehensive advice).
- Information should be transparent about the evidence on which it is based.

4. Increase health literacy among older adults:

- Many older adults would like longer, more in depth consultations with prescribers and to take a greater role in medication decision-making with their doctor, but may not feel empowered to do so.
- Programs that improve older adults' health literacy by increasing their knowledge and confidence could equip this cohort to better engage with health providers and participate in shared decision making.

5. Include information on side-effects of ceasing medication (deprescribing):

- Some older adults said they would be most motivated by the risk of side-effects when deciding to reduce or cease medication use, but these risks aren't always communicated or highlighted.

6. Alcohol-related content should focus on the positive health impacts of cutting back, clearly communicating the evidence on harms. Content should also acknowledge the social role of alcohol for many older adults:

- Campaigns that aim to shift beliefs and behaviours may benefit from clearly explaining the evidence on harms to challenge perceived health benefits of drinking.
- Information on cutting back should highlight the positives of doing so and how it can protect existing health.
- Alcohol plays a positive social role in many older adults' lives, and knowledge of alcohol-related harms alone is unlikely to motivate them to change drinking habits. Messaging should recognise the importance of maintaining meaningful social connections, and ways to do so without drinking, or drinking less riskily.

Interventions:

7. Alcohol-related interventions should consider providing information in various ways:

- Comprehensive content should be offered that includes the health disadvantages of risky drinking; coping strategies and control measures; lifestyle changes regarding personal relationships, nutrition and exercise, and personalised feedback about drinking behaviours.

8. Interventions focused on improving social connectedness and communication:

- Contact with others and conversations about issues around alcohol may be effective in reducing alcohol harms and risky drinking.
- Future research should look at how family and social networks of older adults could contribute to successful alcohol intervention/s.
- Social and leisure opportunities that do not involve alcohol are needed for older adults, for example volunteering, exercise, and group social activities.

9. Interventions which focus on patient empowerment and provide psychological support may be effective in reducing or ceasing benzodiazepine and related medication use:

- Approaches which provide information on stopping medication use and encourage patients to have conversations with prescribers show some effectiveness in ceasing use among older adults, particularly the EMPOWER model.
- Cognitive behavioural therapy for insomnia (CBTi) shows some effectiveness in treating sleep issues and reducing benzodiazepine use among older adults.

Other recommended considerations when developing interventions:

10. Overdose awareness and prevention interventions are needed, particularly around opioids and benzodiazepines:

- Opioids and benzodiazepines continue to be the most common drugs involved in overdose deaths among older Australians, but no interventions focused on overdose awareness or prevention were identified. To fill this gap, educational interventions on how to recognise and respond to overdose are needed, ideally targeting older adults, as well as their partners, family members, and home carers.

11. AOD interventions may benefit from taking a more holistic view of older adults, including mental health and disability:

- Many overdoses were intentional, with self-harm and limitation of activities due to disability the most common contributing psychosocial factors in intentional overdoses. This highlights the complex nature of AOD-related harm, and the need for mental health supports alongside AOD interventions.

12. Risks around polypharmacy use should be clearly communicated to older adults when multiple medications are prescribed, and take home naloxone should be considered when opioids are prescribed:

- Most AOD-induced deaths involve more than one drug class, with opioids and benzodiazepines the most common combination in 2020-21.

13. Remote and very remote areas need greater investment in resources and interventions to reduce harms:

- The highest rates of alcohol-related harm occur in remote and very remote areas. Resources should be allocated to these areas to fund implementation and evaluation of alcohol-related interventions.

Gaps and future directions:

Research is needed around older adults and other drugs including amphetamines and cannabis. Amphetamine-related harms and cannabis use are increasing among older Australians, but there's a lack of research on interventions focused on reducing harms from these substances in this age group.

- Evaluation of interventions for older adults aged 50-59 is needed, in particular any interventions that facilitate the transition from employment to retirement, given that the highest rates of AOD harms among older adults occur in this age group.
- More Australian research on messaging and interventions is needed. Currently there is a lack of local research on older adults.
- Future studies may benefit from focusing on sub-populations of older adults who may have higher rates of AOD use and related harms, such as older people who identify as LGBTIQA+, Aboriginal or Torres Strait Islander or CALD.

References

1. Australian Bureau of Statistics. Snapshot of Australia - Census 2021-2022 [05.06.2024]. Available from: https://www.abs.gov.au/statistics/people/people-and-communities/snapshot-australia/2021.
2. Australian Institue of Health and Welfare. Older Australians 2023 [05.06.2024]. Available from: https://www.aihw.gov.au/reports/older-people/older-australians/contents/summary.
3. Department of Health. National Drug Strategy 2017-2026. 2017 [05.06.2024]. Available from: https://www.health.gov.au/resources/publications/national-drug-strategy-2017-2026?language=en.
4. National Health and Medical Research Council. Australian Guidelines to Reduce Health Risks from Drinking Alcohol. Canberra: Australian Government; 2020 [15.09.2022]. Available from: https://www.nhmrc.gov.au/about-us/publications/australian-guidelines-reduce-health-risks-drinking-alcohol.
5. Australian Institute of Health and Welfare. National Drug Strategy Household Survey 2022–2023. 2024 [12.06.2024]. Available from: https://www.aihw.gov.au/reports/illicit-use-of-drugs/national-drug-strategy-household-survey/contents/about.
6. Australian Institute of Health and Welfare. Alcohol, tobacco & other drugs in Australia 2023 [17.06.2024]. Available from: https://www.aihw.gov.au/reports/alcohol/alcohol-tobacco-other-drugs-australia/contents/priority-populations/older-people.

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