# Acknowledgements

This work was commissioned by the Alcohol and Drug Foundation (ADF), and funded by the Department of Health, Victoria. Two complementary reports were produced as part of this work: the current report, and *Trends in Substance Use and Related Harms Among Australians Aged 50 Years and Older 2001-2021*. Results from the latter report were used to inform the focus of the current report.

# Executive Summary

This report was commissioned by the Alcohol and Drug Foundation (ADF) and presents information regarding: i) preferred sources and content of alcohol and other drug (AOD) related information among older adults, and ii) an overview of evaluated interventions aimed at reducing AOD harms among older adults (defined as ≥50 years).

## Older Adult Preferences

### *Source of information*

- Healthcare providers appear to be the preferred source of AOD information among older adults.
- However, reluctance (from both older adults and practitioners, excluding pharmacists) to engage in conversations around alcohol consumption and its harms was noted, and there was some uncertainty regarding the appropriate etiquette for such discussions.
- Conversations between authorised prescribers and older adults regarding psychotropic medicines are likely more common than conversations regarding alcohol use, though many adults appear to be dissatisfied with the depth and duration of these conversations.
- Many older patients appear to be passive recipients in the prescribing of psychotropic medicines.

### *Content of information*

- One study found that the favoured rationale for deprescribing either preventive or symptomatic relief medicines focused on the risk of side effects.
- Awareness of alcohol-related harms alone is unlikely to motivate older adults to change their consumption, with alcohol playing a positive social role in many older adults' lives.
- However, this may vary depending on the type of 'harm', with one study finding that most older participants who consumed alcohol reported that they would adhere to low-risk guidelines if they were told that doing so could reduce their risk of dementia.
- Engagement with the large segment of the older population who consider themselves to be responsible drinkers, and emphasising their perceived experience of drinking 'wisely' in a controlled manner, could be effective.
- Materials that convey information to older adults about substance use and harms would benefit from use of larger text, actors with whom the viewer can identify based on life stage and, where relevant, subtitles.
- We identified no studies that addressed preferences of older adults regarding conversations about illegal drugs and possible associated harms.

## Evaluated Interventions

- Relatively few evaluations of interventions to reduce AOD-related harms among older adults have been published in the past 10 years, with interpretation of the available evidence complicated by heterogeneity across interventions, outcome measures, and follow-up periods.
- Further, many interventions involved multiple components, with significant reductions often observed in control and/or comparator groups, making it difficult to determine which components of an intervention are effective.

### *Alcohol*

- There is some evidence for the efficacy of brief interventions (including educational tools/leaflets, personalised reports that indicate a participant's own

level of risk, and diaries), and/or psychological treatments.
- A recent systematic review of studies that *included* (but were not specific to) older adults identified three elements of effective interventions: the provision of information on several alcohol-related issues, personalised feedback about drinking behaviours, and being in contact with others and communicating with them about (alcohol) problems.
- There were no identified interventions, specific to older adults, that included the third of these elements (i.e., contact with others). This is a notable omission given the relationship between the use of alcohol in older adults and loneliness.
- One small study found that exercise, in particular yoga, had beneficial effects on alcohol consumption that were comparable to telephone counselling.

### *Benzodiazepines and benzodiazepine receptor agonists*

- Patient-empowerment interventions, in particular EMPOWER, appear to be effective in driving sedative-hypnotic cessation among older adults.
- Two studies found that adding additional components to an educational intervention (e.g., a follow-up call with pharmacist) yielded no improvement in outcomes compared to receiving only the educational component, suggesting that pharmacist contact may not significantly increase discontinuation likelihood beyond the effectiveness of educational materials.

### *Opioids*

- Evidence regarding opioid-related interventions among older adults was particularly limited, noting that the review was restricted to studies published within the past 10 years, and did not include pharmacological interventions such as opioid agonist treatment and naloxone.
- However educational and psychological (primarily the Mindfulness-Oriented Recovery Enhancement model) interventions showed some evidence of effectiveness.
- Community pharmacies may be a valuable resource for identifying and reducing health harm in patients who use pharmaceutical opioids.

### *Other*

- There is limited information in this age group regarding peer-led or co-designed interventions, or interventions that aim to reduce harms associated with illegal substances (including cannabis).
- There is also an absence of information regarding particular subsets of older people that may have higher rates of substance use, including those who identify as LGBTIQA+, First Nations Australians, and those from migrant and multicultural community groups.

See Table 1 for a tabular overview of these key findings, as well as recommendations that are based on the current report, as well as the 'Analysis Report' (i.e., Trends in Substance Use and Related Harms Among Australians Aged 50 Years and Older 2001-2021).

Table 1: High-level summary of findings, and recommendations

| | Aim 1: Preferred sources and content of information [#] | Aim 2: Evaluated interventions to reduce harms among adults aged ≥50 years | Recommendations and identified gaps[##] |
|---|---|---|---|
| **Alcohol** | **Preferred sources**:<br>○ Healthcare providers, yet there was some uncertainty regarding appropriateness of such conversations.<br>○ Personal stories/lived experience.<br><br>**Preferred content**:<br>○ Accessible information (e.g. large font, optional translation, subtitles).<br>○ Age-appropriate characters.<br>○ Transparent information (e.g., how drinking guidelines developed).<br>○ Multi-faceted information: delivered verbally, accompanied by written materials.<br>○ Awareness of alcohol-related harms alone unlikely to motivate changes in consumption, esp. among those who consider themselves healthy. | ○ 22 studies identified: variation in the types of interventions, including intensity, duration and delivery mode.<br>○ Some evidence for the efficacy of brief interventions, and/or psychological treatments.<br>○ One study (small sample size) found yoga had effects on alcohol consumption comparable to telephone counselling.<br>○ Review of studies that *included* (but were not specific to) older adults identified three elements of effective interventions: the provision of information on alcohol-related issues, personalised feedback about drinking behaviours, and contact/communication (re: alcohol problems) with social network. | **Recommendations**<br>○ Training to ensure key healthcare providers are equipped to identify and intervene where drinking patterns may constitute risk of harm.<br>○ Promote social and leisure opportunities that do not involve alcohol.<br>○ Messaging about protecting current level of health.<br>○ Interventions should consider inclusion of educational information and personalised feedback.<br>○ Future research should investigate how social networks could contribute to a successful intervention.<br><br>**Gaps**<br>○ Interventions in rural/remote areas, and among First Nations, LGBTIQ, and migrant and multicultural communities.<br>○ Work-to-retirement interventions.<br>○ Cognition or dementia based outcomes.<br>○ Australian studies. |
| **Benzo** | **Preferred sources**:<br>○ Healthcare providers.<br>○ Yet, older adults often passive in prescribing decisions and dissatisfied with the length and depth of consultations.<br><br>**Preferred content**:<br>○ Accessible information (e.g. large font, optional translation, video subtitles).<br>○ Multi-faceted information: delivered verbally, accompanied by written materials.<br>○ Clear, and comprehensive information.<br>○ One study found that older adults' preferred rationale for deprescribing | ○ 25 studies identified, mostly categorised into education-based interventions and cognitive behavioural therapy for insomnia (CBTi).<br>○ Patient-empowerment interventions, in particular EMPOWER, show some effectiveness in improving sedative-hypnotic cessation among older adults.<br>○ CBTi shows some effectiveness as a multi-dimensional approach to treating sleep problems, and reducing sedative-hypnotic use, among older adults. | **Recommendations**<br>○ Prescribers should adapt communication based on patients' attitudes to medicines and preferences regarding involvement in the decision-making process.<br>○ Programs to improve health literacy.<br>○ Interventions may benefit from focusing on patient-empowerment models, such as EMPOWER.<br><br>**Gaps**<br>○ Evidence for 'younger' older adults (i.e., data predominantly focused on those aged≥ 70 years). |

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| | medicines focused on the risk of side effects. | | ○ Underrepresentation of some populations (e.g., those with psychiatric comorbidity).<br>○ Interventions on overdose awareness/prevention.<br>○ Australian data. |
| **Opioids** | **Preferred sources**:<br>○ Healthcare providers.<br>○ Yet, often passive in prescribing decisions and dissatisfied with the length and depth of consultations.<br><br>**Preferred content**:<br>○ Accessible information (e.g. large font, optional translation, video subtitles).<br>○ Clear, and comprehensive information.<br>○ Multi-faceted information: delivered verbally, accompanied by written materials. | ○ 12 studies identified: considerable variation in the types of interventions that were delivered.<br>○ Educational and psychological (primarily the Mindfulness-Oriented Recovery Enhancement model) interventions showed some evidence of effectiveness.<br>○ Community pharmacies may be a valuable resource for identifying and reducing health harm in patients who use pharmaceutical opioids. | **Recommendations**<br>○ Prescribers should adapt communication based on patients' attitudes to medicines and preferences regarding involvement in the decision-making process.<br>○ Programs to improve health literacy.<br>○ Consider leveraging community pharmacies, and offering take-home naloxone.<br><br>**Gaps**<br>○ Holistic interventions that consider impact of disability on quality of life.<br>○ Evidence for 'older' older adults (i.e., data predominantly focused on those in their 50's).<br>○ Illegal opioids.<br>○ Interventions on overdose awareness/prevention.<br>○ Australian data. |
| **Other substances** | **Preferred sources**: Unknown<br><br>**Preferred content**: Unknown | ○ Notable, near-total lack of evidence in this area.<br>○ Preliminary supportive data for combined therapies in older adults with HIV (CBT + tai chi + text message support). | **Gaps**<br>○ Evident lack of research specific to illegal, or recently medicalised, substances (e.g., cannabis).<br>○ Evaluations of peer-delivered interventions.<br>○ Under-researched populations common across substances: migrant and multicultural community groups, LGBTQIA+, First Nations.<br>○ Australian data. |

[#] Findings were not always specific to these particular substances (e.g., referred to 'medicines' more broadly), but are applicable across a range of substances. [##] Recommendations and gaps are based on the findings from both reports commissioned by the ADF – i.e., the current report, and *Trends in Substance Use and Related Harms Among Australians Aged 50 Years and Older 2001-2021*. Recommendations are also provided, in more detail, in chapter 3 of this report: Recommendations to reduce AOD-related harms among older adults.