THE CHANGING FACE OF ALCOHOL AND OTHER DRUG USE AMONG OLDER AUSTRALIANS

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• Speakers and participants: 
  *local, national and international*

• NCETA conference organising team:
  *Roger Nicholas, Allan Trifonoff, Stacey Appleton and Tania Steenson*

• NCETA RA support:
  *Dr Alice McEntee, Victoria Kostadinov and Jane Fischer*
Purpose and Goal

• Identification of emerging patterns and trends
• Examination of causal and contributory factors
• Current and projected impact on, and response by, services
• Mechanisms for addressing emergent needs
• Enhanced inter-sectoral collaboration, information sharing and network building
Not new issue; but greater imperative

- Increasing interest in, better data about, alcohol and psychoactive drug use among older people
- Building on work of others in Australia, UK, Europe and USA
Perspectives on, and politics of, ageing

• Growing interest in healthy ageing and wellbeing
• Ageing not seen as a disease state nor inevitable degenerative process (restorative health)
• Propensity to pathologise and problematise
• Patronise and hold paternalistic attitudes
• Stigmatise
Defining ‘Older People’

‘... when you now wake up at the same time that you used to go to bed on a Saturday night’.

>55 years; 60 or 65 years
Young old 60-65 to 75
Old 75-85
Very old 85+
Aboriginal and Torres Strait Islander peoples: old at 40
Unprecedented Demographic Changes

Australia’s population is ageing and doing so at a faster rate than ever before (Australia to 2050: Future challenges, 2010).

[Graph showing population growth by age group from 1911 to 2031, with projections for 2021 and 2031 highlighted.]
Changing Age Profile

• Proportion of people 65+ years projected to increase from 14% in 2014 to 18-20% in 2026.

• In 10 years, 1 in 5 Australians will be over 65.
Australia’s Ageing Population

“We are at critical juncture in our history”
JB Hockey

Australia’s population is ageing. Over the next 40 years, the population aged 65 and over are expected to almost double.
Currently there are 4.5 people aged 15-64 for every person aged 65+.
Over the next 40 years, this ratio is forecast to drop to 2.7 people aged 15-64 for every person aged 65+.
(2015 Intergenerational Report: see Charts 1.8 and 1.9)
Currently there are 4.5 people aged 15-64 for every person aged 65+.
Over the next 40 years, this ratio is forecast to drop to 2.7 people aged 15-64 for every person aged 65+.
(2015 Intergenerational Report: see Charts 1.8 and 1.9)
By 2055, approx. 40,000 people will be 100 years old: a **10 fold increase** (2015 Intergenerational Report)

Source: ABS cat. no. 3105.0.65.001, 3101.0 and Treasury projections.
A photo of the actual iceberg purported to have sunk the Titanic
Which drugs ???

* **Alcohol** (& tobacco)
* **Illicits**: cannabis, stimulants, opioids
* **Prescribed**: opioids, benzos, & over-the-counter medications
* **Opioid substitution therapy (OST)/pharmacotherapy** clients
Why Do Older People Use Drugs

For much the same reasons as all of us:

1. Pleasure (Fun)
2. Pain (Forget)
3. Purposeful (Functional)
What’s the issue?

1. Changing Demographics
   • Australia’s population is ageing and is doing so at a faster rate than ever before
   • Advances in health care services => longer healthier lives
   • Dramatic increase the absolute number of older individuals with AOD problems
   • ↓ incentive to change until problems become severe
   • ‘Quick-fix’ culture: view many problems, including medical, as having a quick/simple fix → ‘a pill for all ills’
   • Greater disposable income can facilitate increased AOD use and corresponding problems
Changing Patterns and Prevalence of Alcohol and Drug Use

• Baby boomers used AOD at higher rates than previous generations and many still do
• Baby boomers hold more liberal attitudes towards alcohol, prescription medicines, and illicit drugs
• In Europe and US the number of older people with substance use problems will double over the two decades to 2000-2020

• NSPs, OST and better BBD and other treatments have prevented many AOD-related deaths
  ‘I didn’t think I’d be here’
## Age-related Risk Factors for AOD and Mental Health Problems

- **retirement,**
- **loss of mobility/independence**
- **medical illness,**
- **grief,**
- **social isolation,**
- **identity/role confusion**

### Vulnerability to exploitation

1. Reduced capacity to metabolise AOD (i.e., same intake, more harm)
2. More complex AOD-related physical conditions
3. Multiple morbidities
4. Multiple medications with potential interactions
5. Complex interactions between AOD / age-related cognitive impairment / mental health conditions (e.g., depression)
6. Risk of falls and other injuries
7. Long term exposure to opioids
Attention also needed in relation to...

1. Older people from culturally and linguistically diverse backgrounds
2. Indigenous Australians
3. Older injecting drug users
# Typology of Older AOD Users

<table>
<thead>
<tr>
<th>Maintainers:</th>
<th>Have continued their previously unproblematic use into older age but age-related changes (metabolic, co-morbidities, other medicines) result in increased harms later in life (Nicholas and Roche, 2014)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Survivors:</td>
<td>Early onset users who have a long history of substance use problems which persist into older age and often have resultant co-morbidities (Gossop, 2008)</td>
</tr>
<tr>
<td>Reactors:</td>
<td>Late onset users whose problem use begins in their 50s or 60s and is often associated with stressful events (e.g., bereavement, retirement, marital breakdown or social isolation) (Gossop, 2008)</td>
</tr>
</tbody>
</table>
Women’s Increased Risk

Unique AOD risk factors among older women:
1. Live longer than men
2. Live alone
3. Lack financial independence/security
4. More susceptible to negative effects of AOD due to physical characteristics (eg proportionately more body fat) (Blow & Lawton Barry, 2003)
5. Experience inc. anxiety and sleep disorders and are prescribed anxiolytic and hypnotic medicines (Hollingworth & Siskind, 2010)
6. Experience chronic pain (Pain Australia, 2011)
7. AOD problems may go undetected, resulting in lost intervention opportunities and accumulation of harm over time (Blow & Lawton Barry, 2003).
Population Drinking Trends Over Time

Figure 4.3: Lifetime and single occasion risky (at least monthly) drinking, people aged 14 or older, 2001 to 2013 (per cent)

(a) On average, had more than 2 standard drinks per day.
(b) Had more than 4 standard drinks on 1 occasion at least once a month.
Source: Online Table 4.4.
Approx 30% increase in single occasion risky drinking among 60-69 year olds.

Figure 4.6: Proportion of people exceeding the single occasion risk\(^{(a)}\) guidelines (at least monthly), people aged 12 or older, by age, 2001 to 2013 (per cent).

\(\text{(a)}\) Had more than 4 standard drinks on 1 occasion.

Source: Online Table 4.8.
Single Occasion Risky Drinkers

Proportion of the Australian Population Who Are Single Occasion Risky Drinkers

- 60-69**: 13% (2001), 16% (2013)
- 70+: 8% (2001), 6% (2013)
- 60++: 10% (2001), 12% (2013)
- 12++: 29% (2001), 26% (2013)


** Statistically significant difference between 2001 and 2013 at p<.01
* Statistically significant difference between 2001 and 2013 at p<.05
>2 drinks on a regular basis

Figure 4.5: Proportion of people exceeding the lifetime risk (a) guidelines, people aged 12 or older, by age, 2001 to 2013 (per cent)

(a) On average, had more than 2 standard drinks per day.
Source: Online Table 4.8.
Proportion of the Australian Population Who Are Lifetime Risky Drinkers

**Statistically significant difference between 2001 and 2013 at p<.01**

## Risky Alcohol Use: NDSHS Data 2001 & 2013 by age groups (NCETA secondary analysis 2015)

<table>
<thead>
<tr>
<th>Age Group</th>
<th>2001</th>
<th>2013</th>
<th>z-score</th>
<th>p-value (one tailed)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Lifetime risky drinkers</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>60-69 years</td>
<td>15.5%</td>
<td>18.6%</td>
<td>-3.38</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>70+ years</td>
<td>12.4%</td>
<td>10.1%</td>
<td>2.89</td>
<td>0.002</td>
</tr>
<tr>
<td>60+ years</td>
<td>14.0%</td>
<td>14.7%</td>
<td>-1.22</td>
<td>0.111</td>
</tr>
<tr>
<td>12+ years</td>
<td>20.5%</td>
<td>17.6%</td>
<td>5.45</td>
<td>0.000</td>
</tr>
<tr>
<td><strong>Single occasion risky drinkers</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>60-69 years</td>
<td>12.5%</td>
<td>16.3%</td>
<td>-4.43</td>
<td>0.000</td>
</tr>
<tr>
<td>70+ years</td>
<td>7.5%</td>
<td>6.3%</td>
<td>0.88</td>
<td>0.030</td>
</tr>
<tr>
<td>60+ years</td>
<td>10.0%</td>
<td>11.7%</td>
<td>3.12</td>
<td>0.001</td>
</tr>
<tr>
<td>12+ years</td>
<td>29.2%</td>
<td>25.7%</td>
<td>8.79</td>
<td>0.000</td>
</tr>
</tbody>
</table>
Frequency of Australian alcohol consumption by age 2010 NDSHS
Figure 4.2: Daily drinking, people aged 12 or older, by age, 2004 to 2013 (per cent)
Increasing Proportions of Risky Drinkers Among 60-69 year olds

Between 2001 and 2013:

• Single occasion risky drinkers significantly increased by 31% (from 12.4% to 16.3%)

• Lifetime risky drinkers (ie consuming >2 standard drinks a day) significantly increased by 20% (from 15.5% to 18.6%)

(NDSHS data)
# Alcohol: Principal Drug of Concern

## Episodes of Treatment


<table>
<thead>
<tr>
<th>Year</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>2002−03</td>
<td>1,975</td>
<td>82.0</td>
</tr>
<tr>
<td>2003−04</td>
<td>2,051</td>
<td>82.3</td>
</tr>
<tr>
<td>2004−05</td>
<td>2,210</td>
<td>81.1</td>
</tr>
<tr>
<td>2005−06</td>
<td>2,252</td>
<td>81.3</td>
</tr>
<tr>
<td>2006−07</td>
<td>2,441</td>
<td>83.8</td>
</tr>
<tr>
<td>2007−08</td>
<td>3,139</td>
<td>83.5</td>
</tr>
<tr>
<td>2008−09</td>
<td>3,067</td>
<td>83.1</td>
</tr>
<tr>
<td>2009−10</td>
<td>3,499</td>
<td>84.7</td>
</tr>
<tr>
<td>2010−11</td>
<td>3,607</td>
<td>80.6</td>
</tr>
<tr>
<td>2011−12</td>
<td>3,935</td>
<td>82.7</td>
</tr>
<tr>
<td>2012−13</td>
<td>3,693</td>
<td>79.6</td>
</tr>
</tbody>
</table>
Alcohol as Principal Drug of Concern for AODTS Clients Aged 60+ Years: 2002-2013

Source: Australian Institute of Health and Welfare (AIHW).
2002/03 – 2012/13 Alcohol and Other Drug Treatment Services
(NCETA secondary analysis, 2015).
Alcohol-caused hospital separations by age group, 2009-10

Deaths due to alcohol-caused diseases by age group

Figure 5.4: Illicit use of any drug\(^{(a)}\), people aged 14 or older, by age, 2001 to 2013 (per cent)

\(^{(a)}\) Used at least 1 of 17 illicit drugs in the previous 12 months in 2013; the number and type of illicit drug used varied between 1995 and 2013.

Source: Online Table 5.6.
Figure 5.6: Recent (a) use of cannabis, people aged 14 or older, by age, 2001 to 2013 (per cent)
Recent\(^1\) Cannabis Use

Proportion of the Australian Population Who Used Cannabis in the Past 12 Months

<table>
<thead>
<tr>
<th>Age Group</th>
<th>2001</th>
<th>2013</th>
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<tbody>
<tr>
<td>60+***</td>
<td>0.5%</td>
<td>1.2%</td>
</tr>
<tr>
<td>14+</td>
<td>12.9%</td>
<td>10.2%</td>
</tr>
</tbody>
</table>

** Statistically significant difference between 2001 and 2013 at p<.01.**

\(^1\) Used cannabis in the past 12 months.

Source: Australian Institute of Health and Welfare (AIHW).
## Principal Drug of Concern: Cannabis

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</thead>
<tbody>
<tr>
<td><strong>Frequency</strong></td>
<td>28</td>
<td>37</td>
<td>54</td>
<td>49</td>
<td>49</td>
<td>79</td>
<td>72</td>
<td>90</td>
<td>211</td>
<td>0</td>
<td>187</td>
</tr>
<tr>
<td><strong>Percentage</strong></td>
<td>1.16%</td>
<td>1.48%</td>
<td>1.98%</td>
<td>1.77%</td>
<td>1.68%</td>
<td>2.10%</td>
<td>1.95%</td>
<td>2.18%</td>
<td>4.71%</td>
<td>0%</td>
<td>4.0%</td>
</tr>
</tbody>
</table>

Source: Australian Institute of Health and Welfare (AIHW).  
2002/03 – 2012/13 Alcohol and Other Drug Treatment Services (NCETA secondary analysis, 2015).
Principal Drug of Concern: Cannabis

Cannabis as Principal Drug of Concern for AODTS Clients
Aged 60+ Years: 2002-2013

Source: Australian Institute of Health and Welfare (AIHW).
2002/03 – 2012/13 Alcohol and Other Drug Treatment Services
(NCETA secondary analysis, 2015).
Pharmaceutical Drug Misuse
Prescribed Opioids

Between 1992-2012 there was a 15 fold increase in the number of PBS listed opioid dispensing episodes.

Oxycodone was the main contributor to increased opioid use.

Dramatic increase in fentanyl
Figure 2. Prescriptions for oxycodone dispensed on the Australian Pharmaceutical Benefits Scheme from 2002 to 2008, per thousand population, by 10-year age groups.
Pharmaceutical base supply: selected opioids, Australia, 1991-2010 (Dobbin, 2011)

17 fold increase in supply of oxycodone from 1999 - 2010
Pharmaceutical Misuse 2001 to 2013 (NDSHS)

Figure 6.1: Recent\(^{(a)}\) misuse of pharmaceuticals, people aged 14 or older by drug type, 2001 to 2013 (per cent)

\(^{(a)}\) Used in the previous 12 months.
\(^{(b)}\) Non-maintenance.
\(^{(c)}\) Did not include buprenorphine before 2007.

Source: Online Table 6.2.
Figure 6.2: Recent\textsuperscript{(a)} misuse of pharmaceuticals, people aged 14 or older by age, 2001 to 2013 (per cent)
Count of hospital separations for poisonings for heroin (T40.1), other opioids (T40.2), methadone (T40.3), and other and unspecified narcotics (T40.6), for persons aged 60+ years

Proportion of hospital separations for poisonings from heroin (T40.1), other opioids (T40.2), methadone (T40.3), and other and unspecified narcotics (T40.6), for persons aged 60+ years

Average length of stay for all poisonings (40.1, 40.2, 40.3, 40.4, 40.5, 40.6, 40.7) by Age (15 years or older)
Deaths associated with oxycodone increased 7 fold in an 11 year period

Oxycodone-related deaths and oxycodone defined daily doses (DDD) per million pop per day, against the number of oxycodone-related deaths Australia-wide, 2001-2011 (Pilgrim et al., 2015)
Fentanyl prescriptions per 1000 population in Australia by age 2002/03 – 2010/11.

(Drug Utilisation Sub-Committee of the Pharmaceutical Benefits Advisory Committee cited in Roxburgh, et al., 2013).
Prescribed Opioids: A Gateway to Heroin?

Recent and growing evidence that prescribed opioid use among older people may act as a gateway to heroin use (Dertadian & Maher, 2014; Kolodny et al., 2015; Lankenau et al., 2012; Mars, Bourgois, Kandinos, Montero, & Ciccarone, 2014).

Speculation that increasing medicalisation of cannabis for the treatment of pain and other conditions may enhance uptake among older people for non-medical purposes.
Increases in AOD Treatment Demand

• Between 2003-04 and 2012-13 the proportion of AOD treatment episodes increased from:
  – 5.7% - 8.19% for 50-59 year olds
  – And from 1.9% - 2.9% for >60 year olds

(AIHW [2004], AIHW [2014])
In 2013 approximately 47,442 people were receiving opioid substitution or pharmacotherapy in Australia: about 1 in 5 are over 50 years of age.
Increasing Age of OST Clients

• Between 2006–2013 the proportion of OST clients aged <30 more than halved (from 28% to 11%),
• those aged >50+ more than doubled (from 8% to 19%)

(AIHW, 2014).
Clients receiving pharmacotherapy on a snapshot day, 50+ years, 2006-13

What’s Needed

1. Better assessment tools
2. Identification of ‘safer’ levels of use
3. Provision of support for, and collaboration with, for aged care / community services
4. Clearer advice to older people and those who live/work/interact with them to prevent problems from developing
Figure 2: Alcohol and drug problems of Intoxication, regular hazardous use and dependence
The spectrum of alcohol and drug (AOD) problems

- No AOD Use: Prevention, Minimal intervention
- Unproblematic AOD Use: Brief intervention, Harm reduction, Medical assessment
- Problematic AOD Use: Intensive treatment, Counselling, Detoxification, Maintenance therapy, Withdrawal regime, Relapse prevention
Barriers to treatment

1. Shame, embarrassment (feelings of past ‘failures’)
2. Physical access to services (transport, stairs etc.)
3. Attributing AOD-related symptoms to ageing
4. Unsuitable services
5. Collusion by client’s family
6. Not knowing where to turn for help

Older people do well in treatment!!
Health professional barriers to treatment

1. A lack of awareness about AOD problems and older people
2. Inability to identify signs and symptoms of AOD problems in older people
3. Lack of confidence / skills
4. Reluctance to ask ‘embarrassing’ questions of older people
5. Believe older people too old to change
6. Believe it wrong to ‘deprive’ older people of ‘last pleasures in life’
Nudging Works

Even subtle changes can make important differences in behaviour – including ‘lifestyle’ choices in regard to food and drink.

Google reduced worker caloric intake x 3 million
Massive Open Online Course (MOOC)

Falling Down: Older People and Substance Use

What is a MOOC?
- is a freely available, short online course
- brings people together in active, open forums where ideas, issues and subject expertise can be developed, debated, expanded, and applied within dynamic, accessible, and global open spaces
- usually does not restrict the number of participants
- may include similar materials to traditional online courses (e.g., videos, readings, learning activities)
- may differ from traditional online courses particularly in the way that people participate, (e.g., facilitative/self-directed).

Falling Down: Older People and Substance Use

The Falling Down: Older People and Substance Use MOOC will:
- Explore problematic AOD use among older people
- Promote awareness of the challenges of working with older people
- Identify possible steps to meet those challenges including treatment options and examples of best practice.

International Collaboration
The National Centre for Education and Training on Addiction (NCETA) is a member of the Global Addiction academy Project (GAaP) coordinated by Middlesex University, UK.

GAaP provides an international forum for shared learning and exploration of addiction issues across countries including policy and practice, workforce development, service provision, treatment and research.

In recognition of a growing awareness about changes in patterns of alcohol and other drug (AOD) use among older people and resultant levels of harm, NCETA is partnering with international colleagues to develop Falling Down: Older People and Substance Use MOOC. Partners include researchers from:
- Middlesex University, UK (Lead Agency)
- Manchester Metropolitan University, UK
- Drexel University, US
- Matua Raki, NZ.

The MOOC will be available online in the latter part of 2015.
RESULTS

AUSTRALIAN HOSPITAL SEPARATIONS FOR OPIOID POISONINGS 1998/99 2011/12

- Number of hospital separations
- Gender adjusted hospital separations
- Age adjusted hospital separations
- Average length of stay
Australian age adjusted opioid poisoning hospital separations rate per 1,000,000 1998-99 to 2011-12

Secondary analysis of Australian Institute of Health and Welfare data undertaken by the National Centre for education and Training on Addiction, 2014)
Figure 1: Total crude hospital separations from drug-related poisonings from 1998-2011

- **T40.1 and T40.3** (Heroin and Methadone)
- **T40.2 and T40.6** (Other opioids and Other and unspecified narcotics)
- **All poisonings (40.1, 40.2, 40.3, 40.4, 40.5, 40.6, 40.7)**
Figure 2: Sex adjusted rate of Opioid poisoning hospital separations per 1,000,000
Figure 3: Age adjusted opioid poisoning hospital separations rate per 1,000,000
Figure 7: Age adjusted opioid poisoning hospital separations rate per 1,000,000 (15 years and older)
Figure 4: Average length of stay per drug-related poisoning type

- T40.1 and T40.3 (Heroin and Methadone)
- T40.2 and T40.6 (Other opioids and Other and unspecified narcotics)
- Total (40.1, 40.2, 40.3, 40.4, 40.5, 40.6, 40.7)
Figure X: Age adjusted hospital separations for heroin (T40.1), other opioids (T40.2), methadone (T40.3), and other and unspecified narcotics (T40.6), for persons aged 60+ years (per 1,000,000)

**Figure X:** Proportion of hospital separations for heroin (T40.1), other opioids (T40.2), methadone (T40.3), and other and unspecified narcotics (T40.6), for persons aged 60+ years (age adjusted, per 1,000,000)