



**NCETA**

*Australia's National Research Centre  
on AOD Workforce Development*



**FLINDERS  
UNIVERSITY**

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

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*local, national and international*

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# 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

NATIONAL PHARMACEUTICAL  
DRUG MISUSE  
FRAMEWORK FOR ACTION  
(2012-2015)

A MATTER OF BALANCE



## GREY MATTERS

Preventing and responding to  
alcohol and other drug problems  
among older Australians:

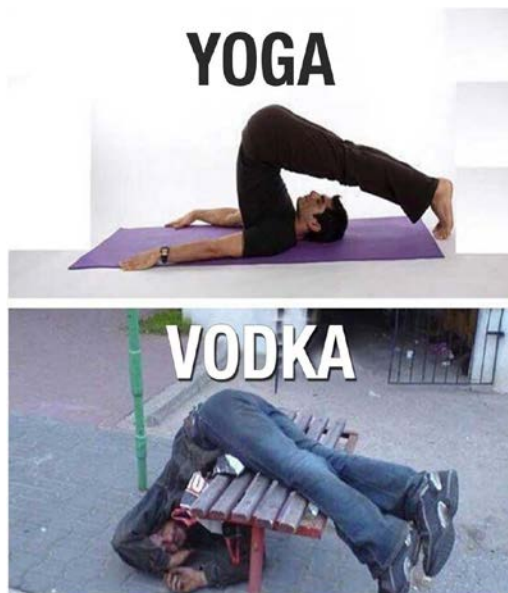
An information series



- Increasing interest in, better data about, alcohol and psycho-active 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*

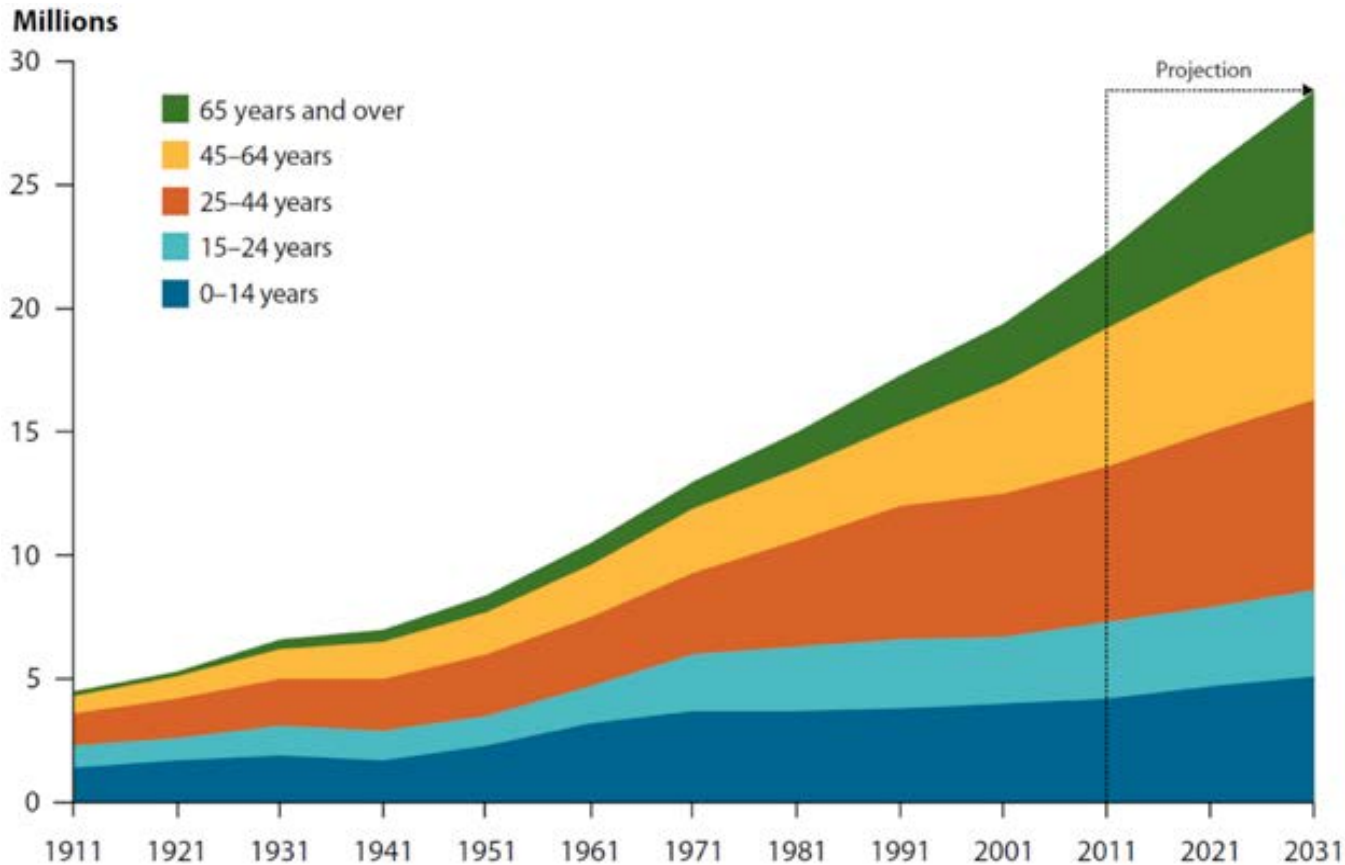
*Old 75-85*

*Very old 85+*

Aboriginal and Torres Strait  
Islander peoples: old at 40

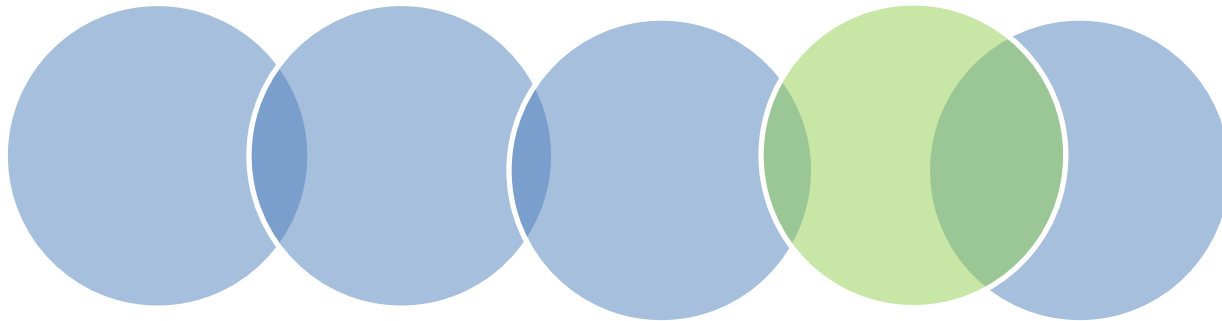
# Unprecedented Demographic Changes

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



# 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.





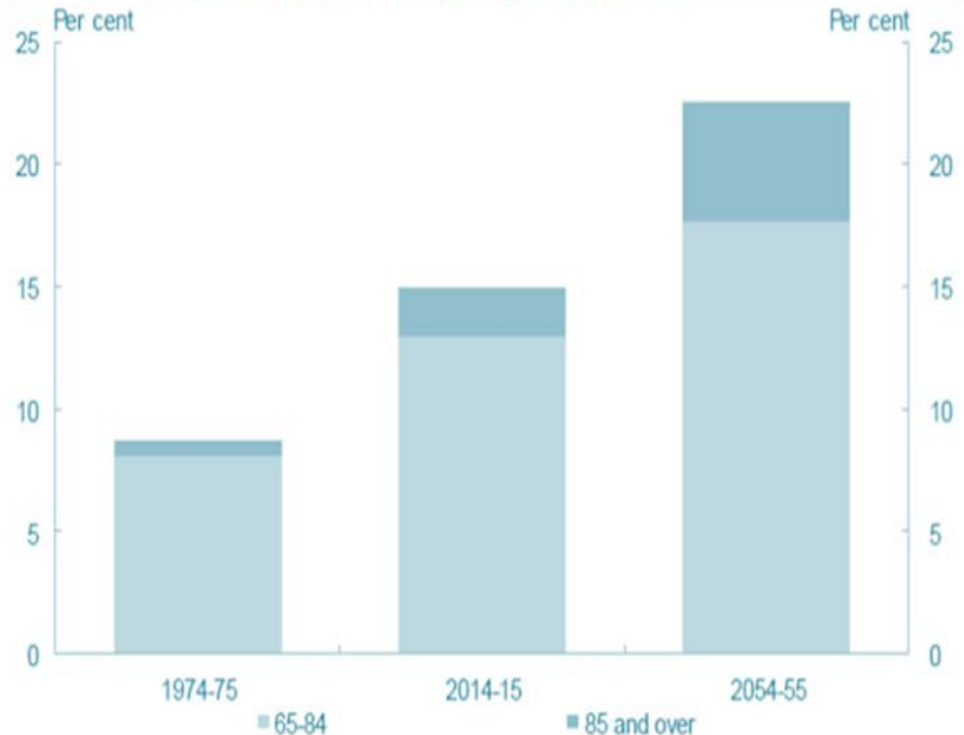
# Australia's Ageing Population

**“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.

Chart 1.6 Proportion of population aged 65 and over



Source: ABS cat. no. 3105.0.65.001, 3101.0 and Treasury projections.

2015 Intergenerational Report  
Australia in 2055

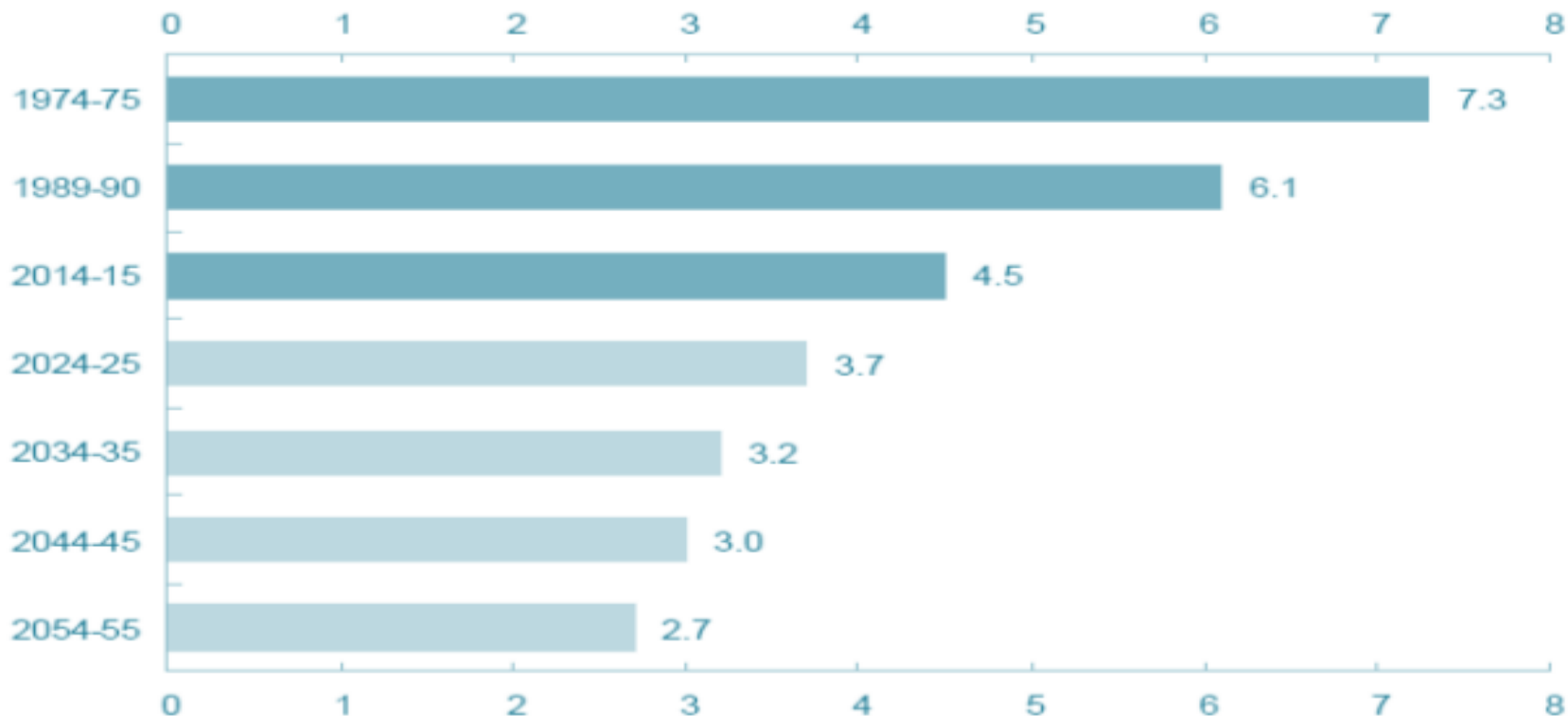
Circulated by  
The Honourable J. B. Hockey MP  
Treasurer of the Commonwealth of Australia

March 2015

**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)

**Chart 1.9 Number of people aged from 15 to 64 relative to the number of people aged 65 and over**



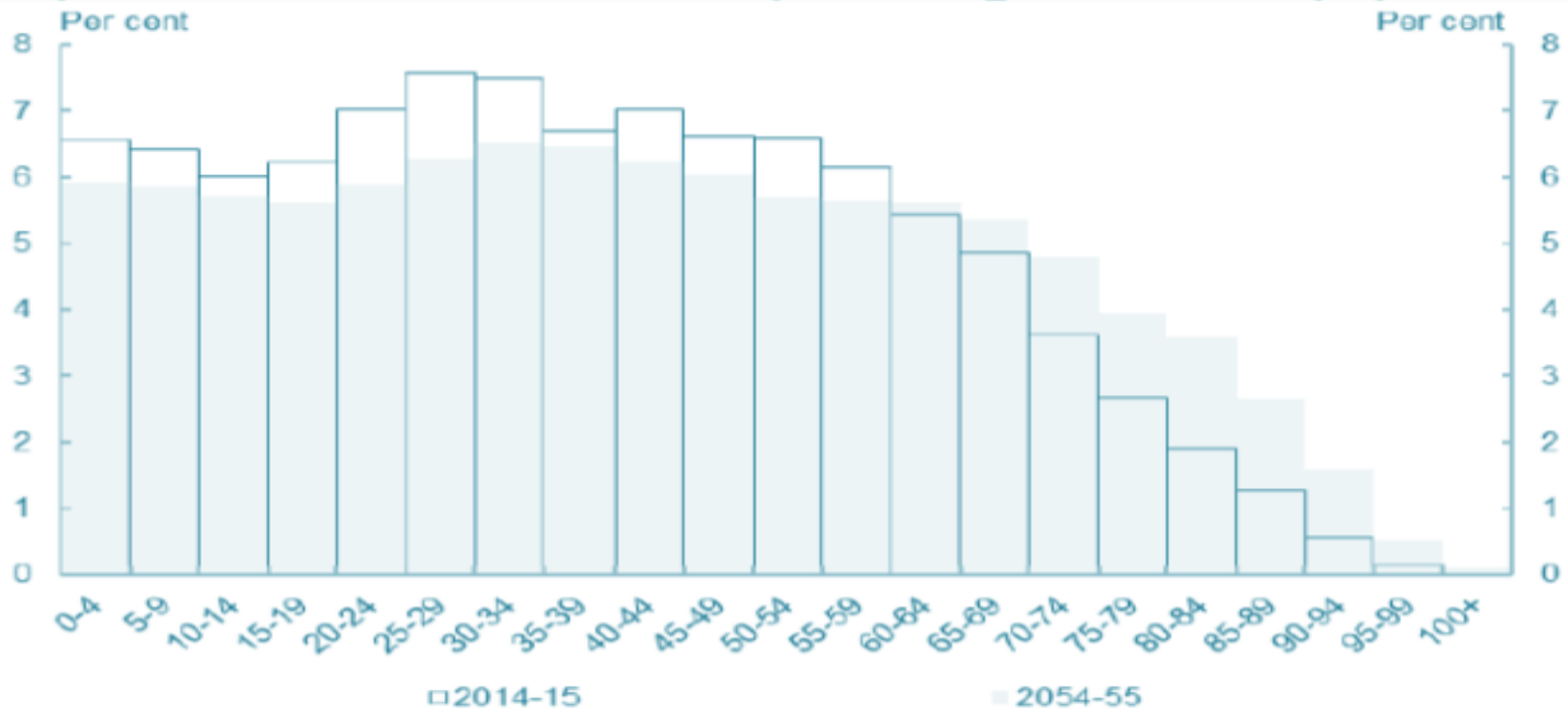
Source: ABS cat. no. 3105.0.65.001, 3101.0 and Treasury projections.

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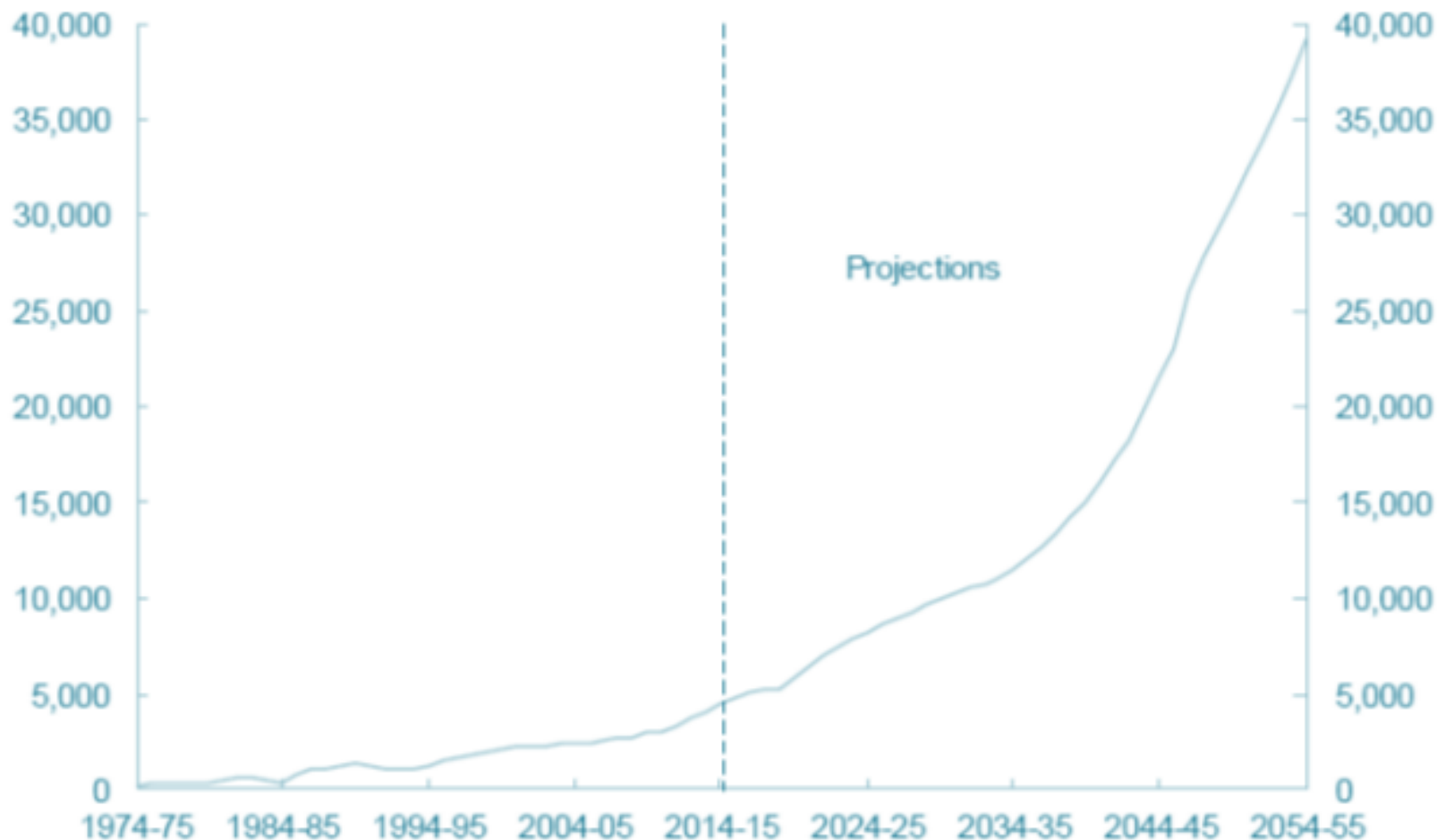
**Chart 1.8** Proportion of the Australian population in different age groups in 2014-15 and 2054-55 as a percentage of the total population



Source: Treasury projections.

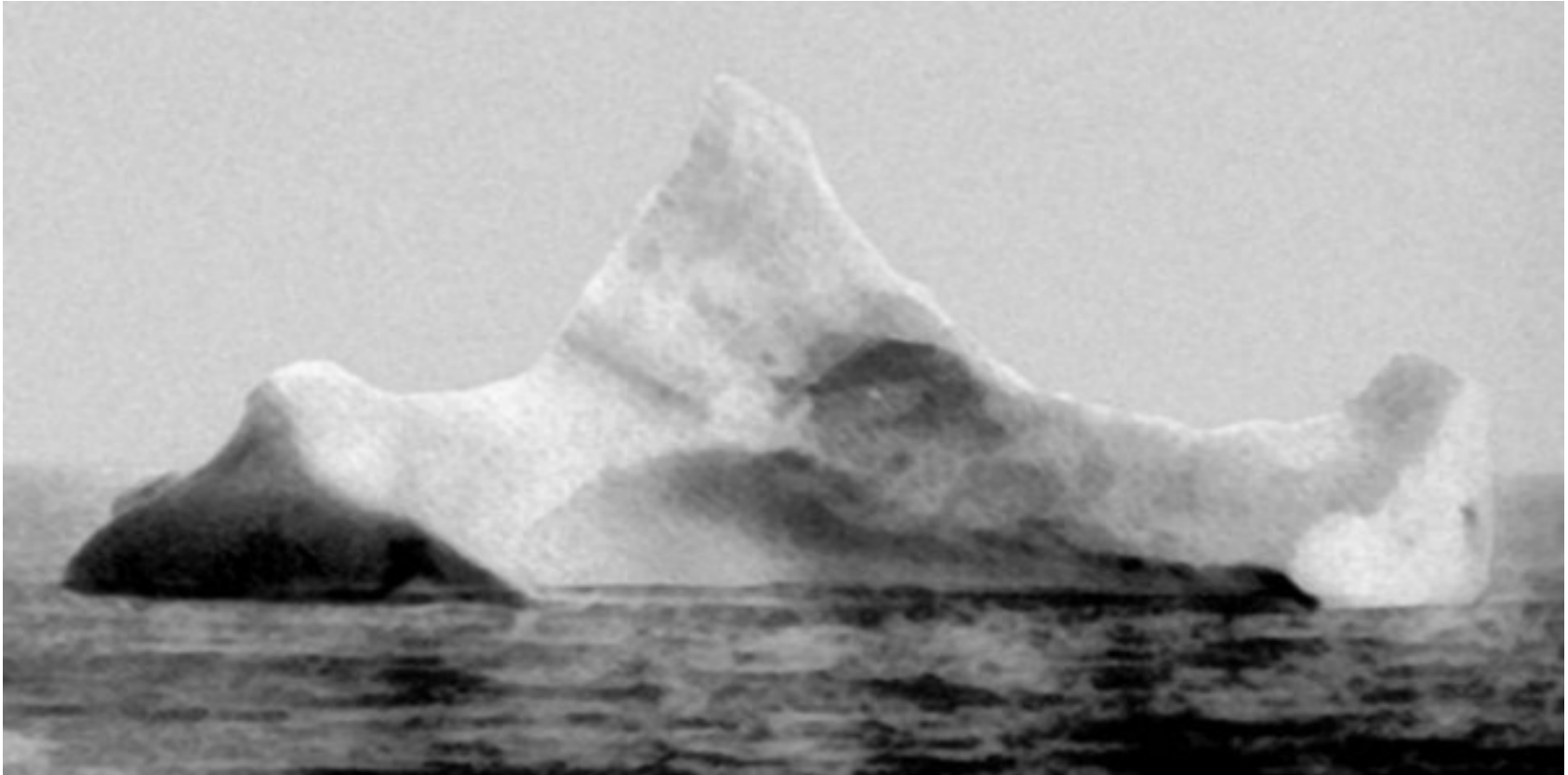
**By 2055, approx. 40,000 people will be 100 years old :  
a 10 fold increase** (2015 Intergenerational Report)

**Chart 1.7** Number of centenarians



Source: ABS cat. no. 3105.0.65.001, 3101.0 and Treasury projections.

# Tip of the Iceberg



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 betw AOD / age-related cognitive impairment / mental health conditions (eg 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

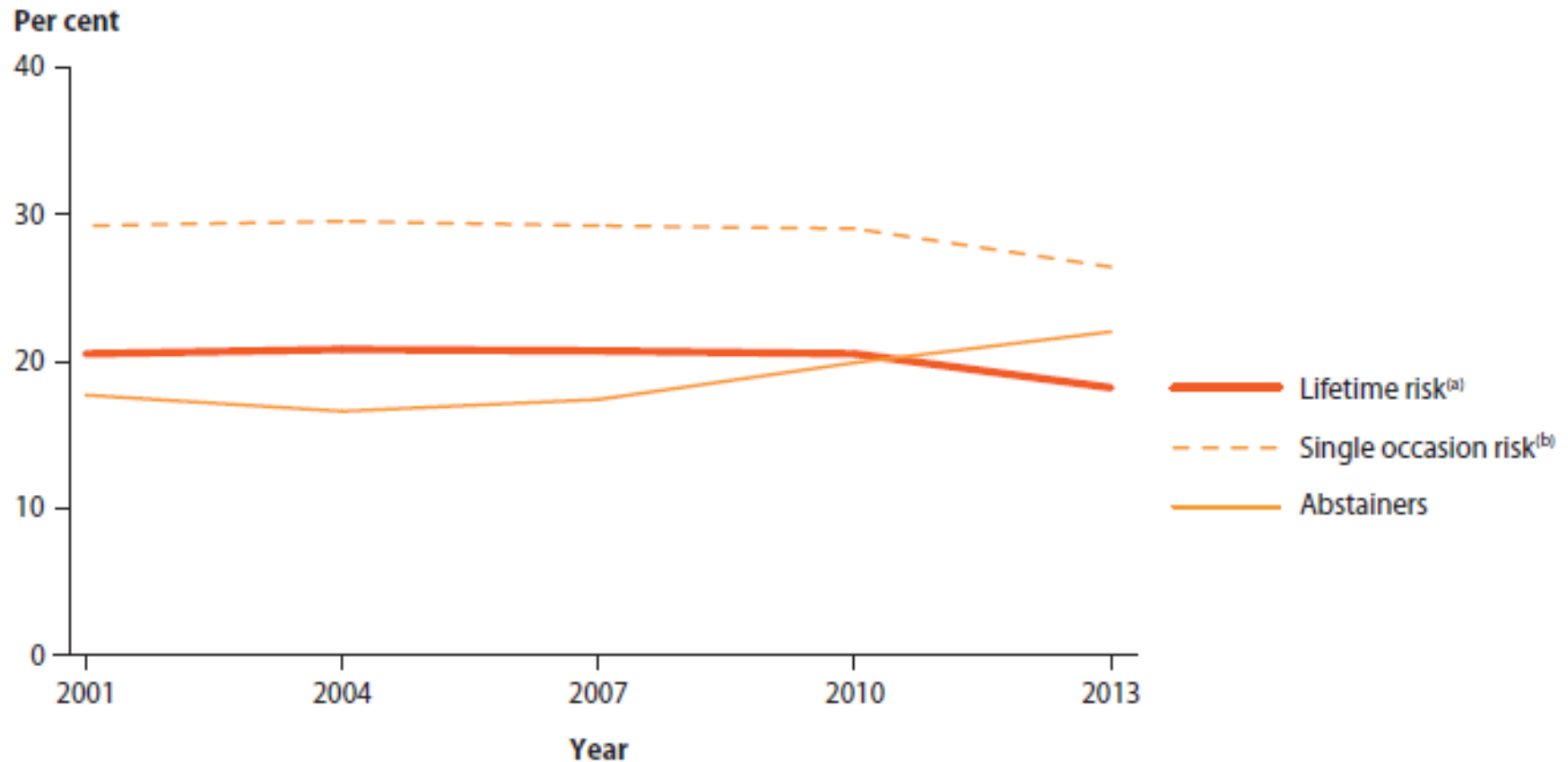
<b>Maintainers:</b>	<b>Have continued their previously unproblematic use into older age but age-related changes (metabolic, co-morbidities, other medicines) result in increased harms later in life (Nicholas and Roche, 2014)</b>
<b>Survivors:</b>	Early onset users who have a long history of substance use problems which persist into older age and often have resultant co-morbidities (Gossop, 2008)
<b>Reactors:</b>	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)

# 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



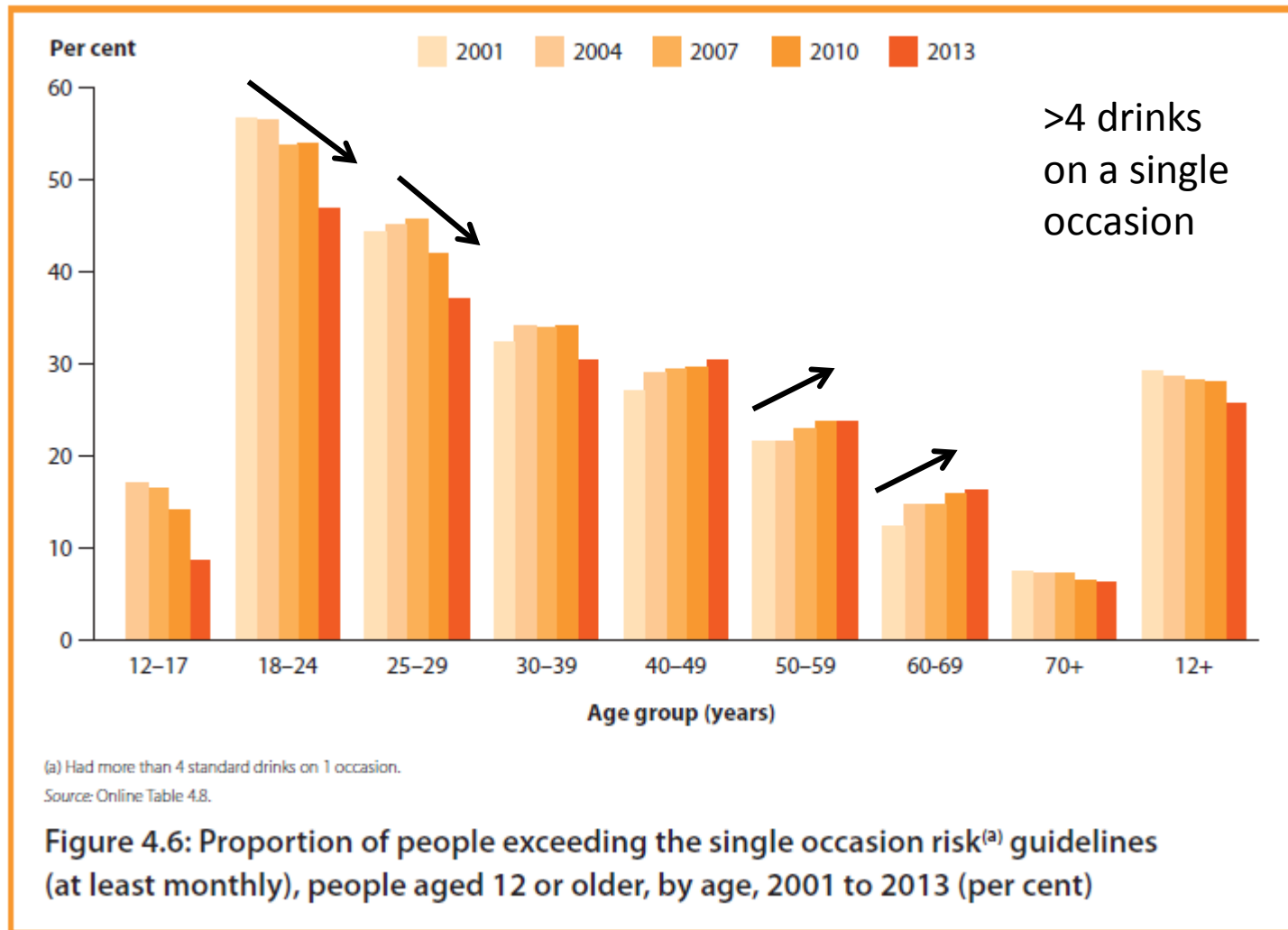
(a) On average, had more than 2 standard drinks per day.

(b) Had more than 4 standard drinks on 1 occasion at least once a month.

Source: Online Table 4.4.

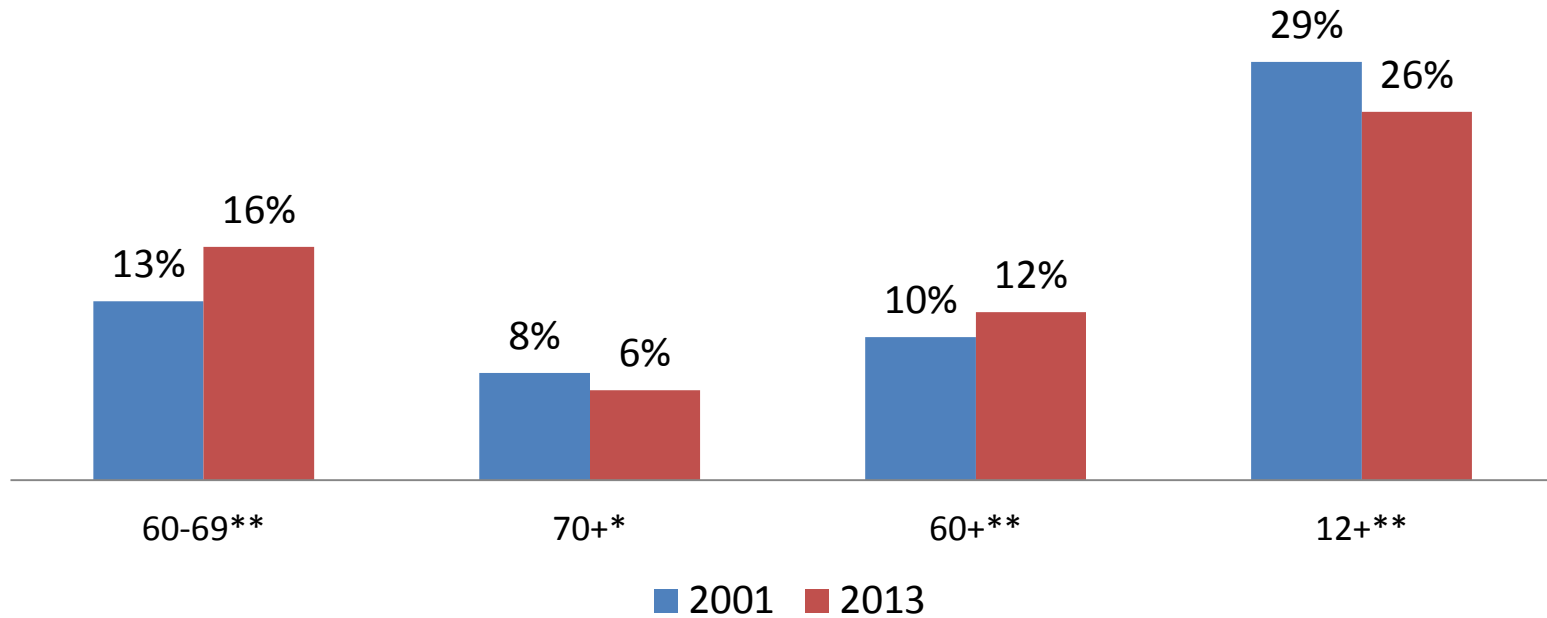
**Figure 4.3: Lifetime and single occasion risky (at least monthly) drinking, people aged 14 or older, 2001 to 2013 (per cent)**

# Approx 30% increase in single occasion risky drinking among 60-69 year olds



# Single Occasion Risky Drinkers

Proportion of the Australian Population Who Are Single Occasion Risky Drinkers

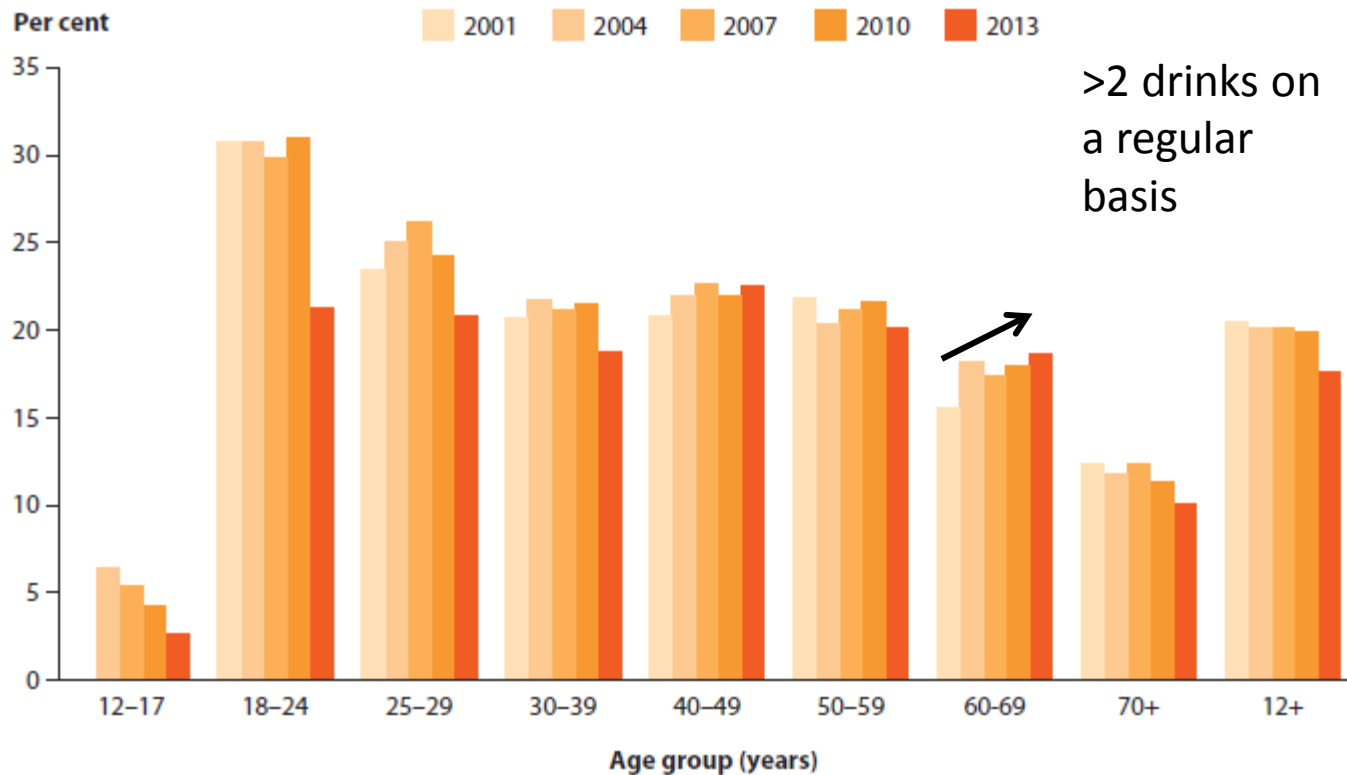


Source: Australian Institute of Health and Welfare (AIHW).  
2001 and 2013 National Drug Strategy Household Survey  
(NCETA secondary analysis, 2015).

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

\* Statistically significant difference between 2001 and 2013 at  $p < .05$





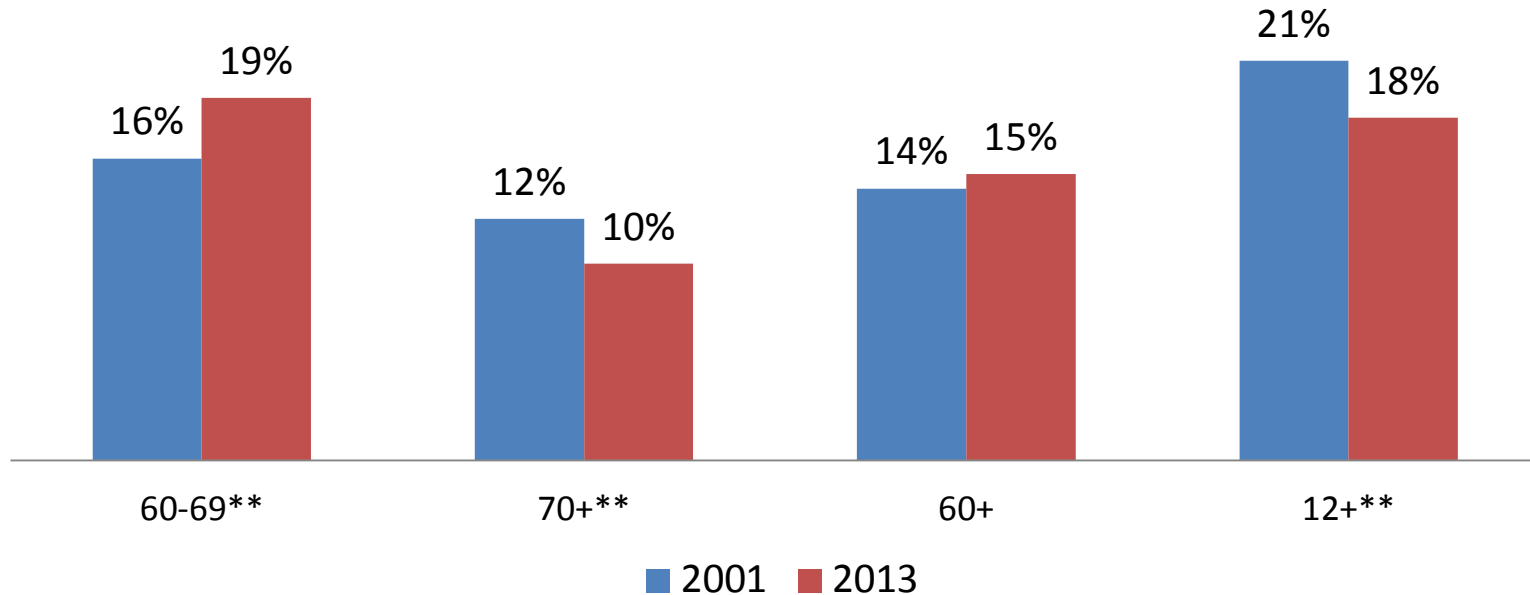
(a) On average, had more than 2 standard drinks per day.

Source: Online Table 4.8.

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

# Lifetime Risky Drinkers

Proportion of the Australian Population Who Are Lifetime Risky Drinkers



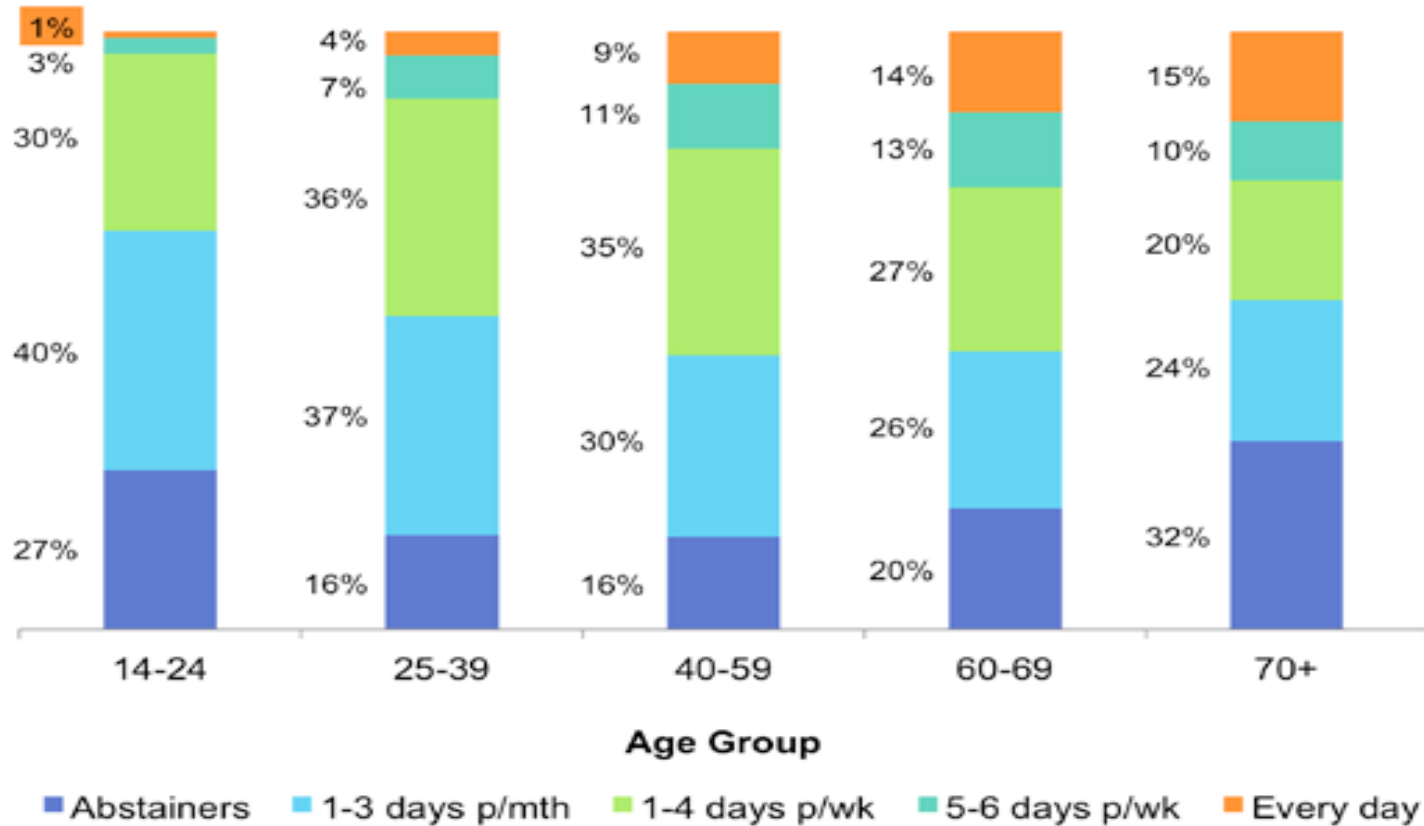
Source: Australian Institute of Health and Welfare (AIHW).  
2001 and 2013 National Drug Strategy Household Survey  
(NCETA secondary analysis, 2015).

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

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

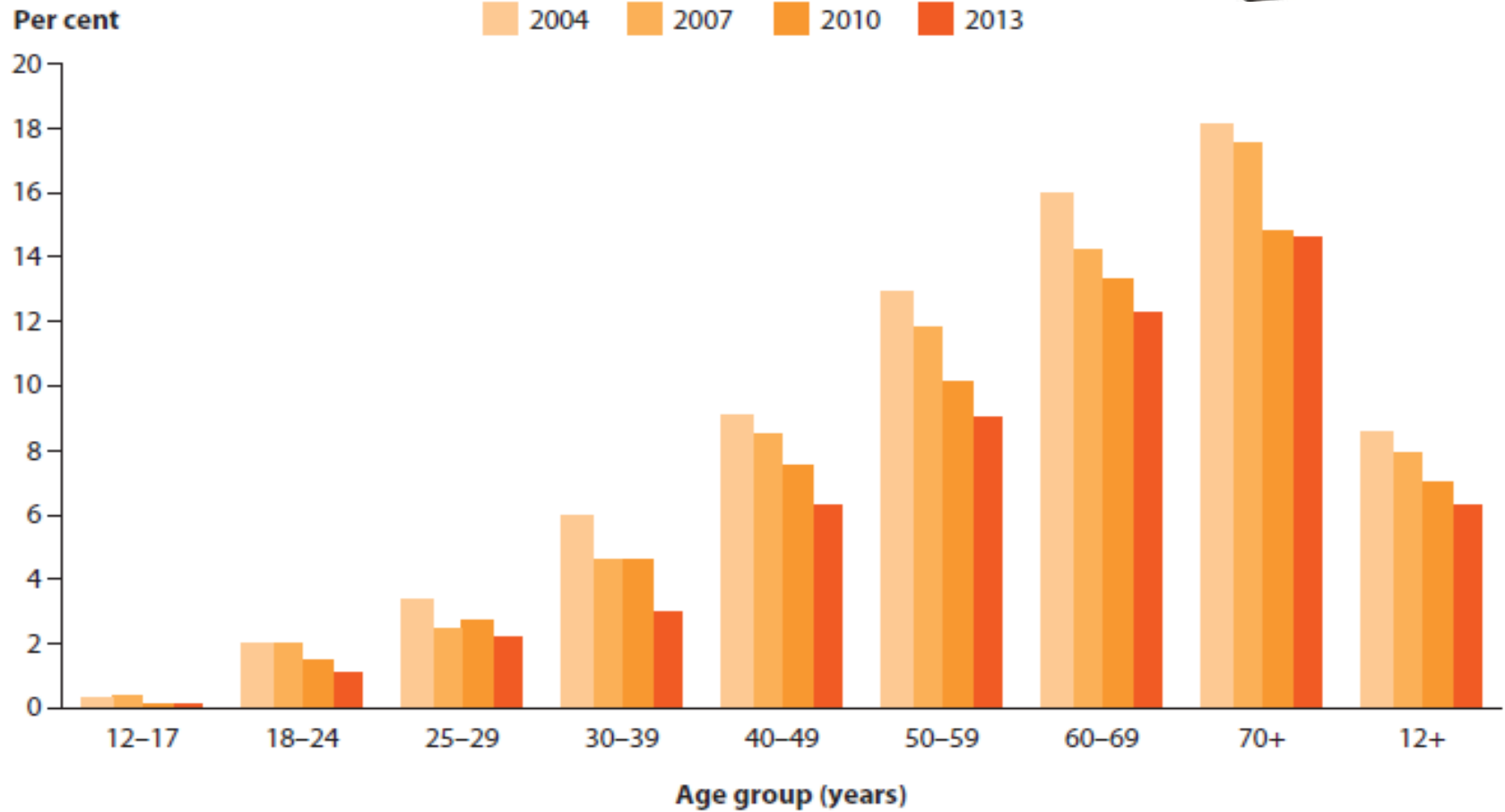
Age Group	2001	2013	z-score	p-value (one tailed)
<b>Lifetime risky drinkers</b>				
60-69 years	15.5%	18.6%	-3.38	<0.001
70+ years	12.4%	10.1%	2.89	0.002
60+ years	14.0%	14.7%	-1.22	0.111
12+ years	20.5%	17.6%	5.45	0.000
<b>Single occasion risky drinkers</b>				
60-69 years	12.5%	16.3%	-4.43	0.000
70+ years	7.5%	6.3%	0.88	0.030
60+ years	10.0%	11.7%	3.12	0.001
12+ years	29.2%	25.7%	8.79	0.000

# Frequency of Australian alcohol consumption by age 2010 NDSHS





# Daily Drinking



Source: Online Table S4.14.

**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%)

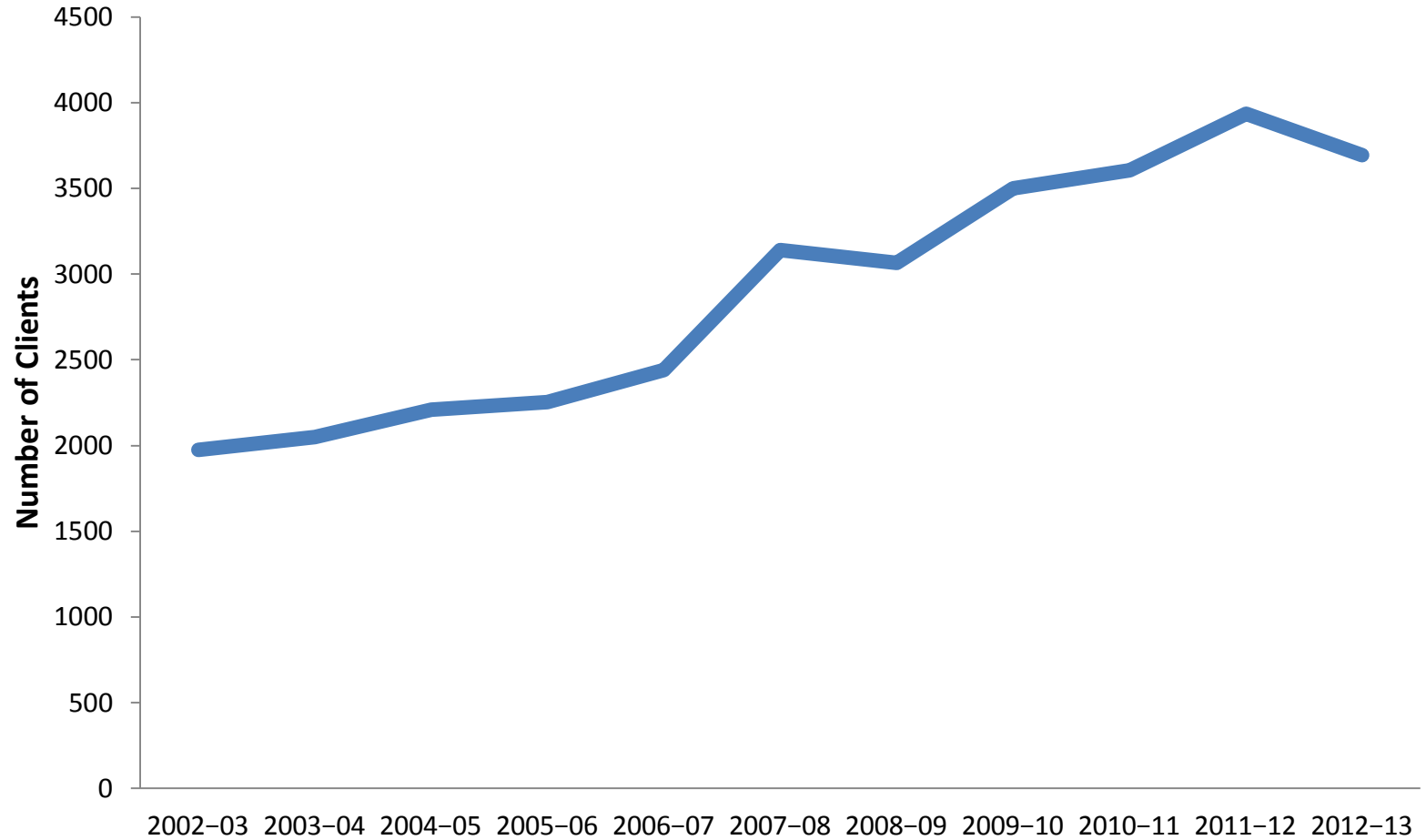
(NDSHS data)

# Alcohol: Principal Drug of Concern Episodes of Treatment

	2002– 03	2003– 04	2004– 05	2005– 06	2006– 07	2007– 08	2008– 09	2009– 10	2010– 11	2011– 12	2012– 13
Frequency	1,975	2,051	2,210	2,252	2,441	3,139	3,067	3,499	3,607	3,935	3,693
Percentage	82.0	82.3	81.1	81.3	83.8	83.5	83.1	84.7	80.6	82.7	79.6

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

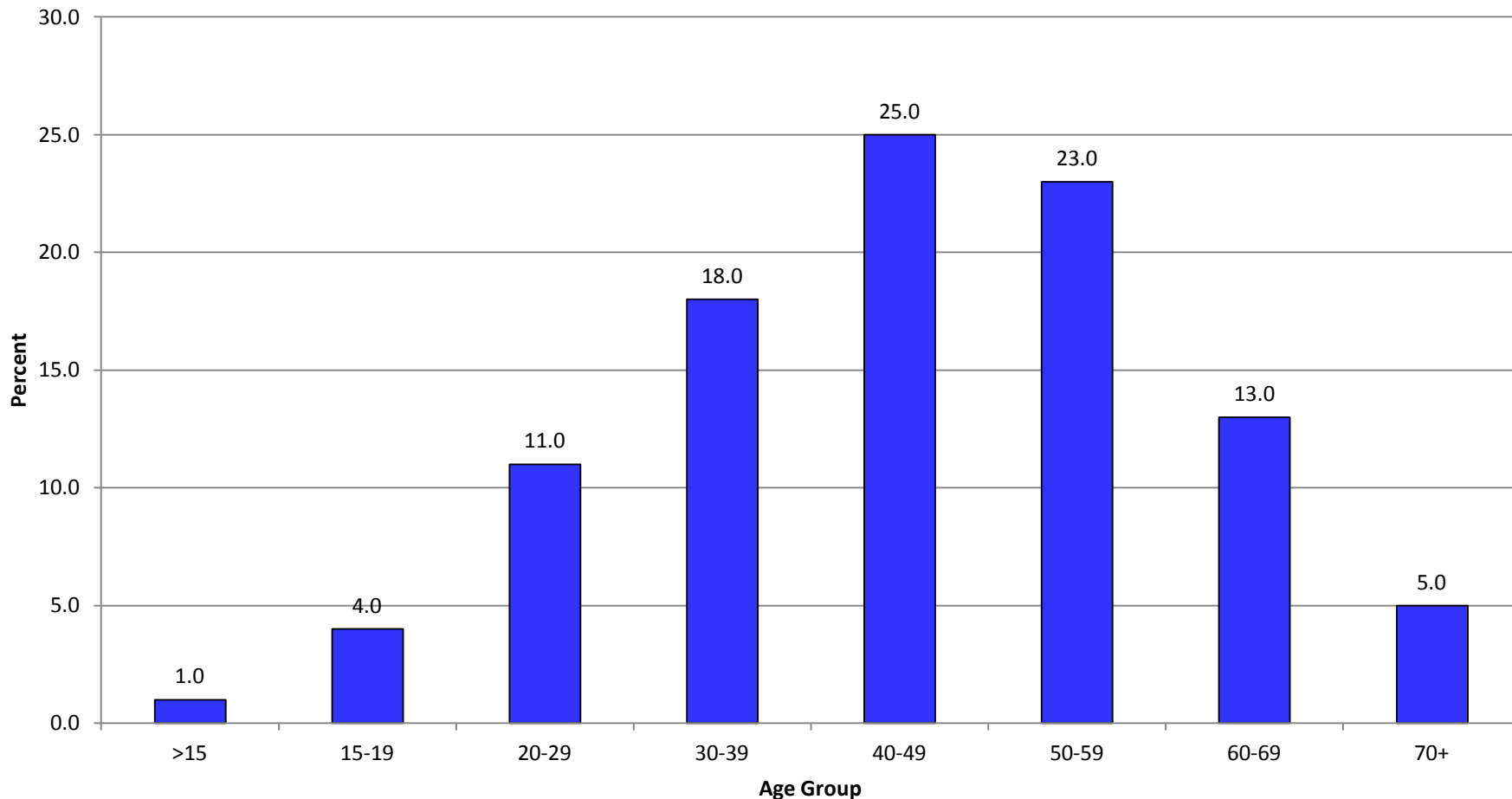
# Alcohol as Principal Drug of Concern for AODTS Clients Aged 60+ Years: 2002-2013



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

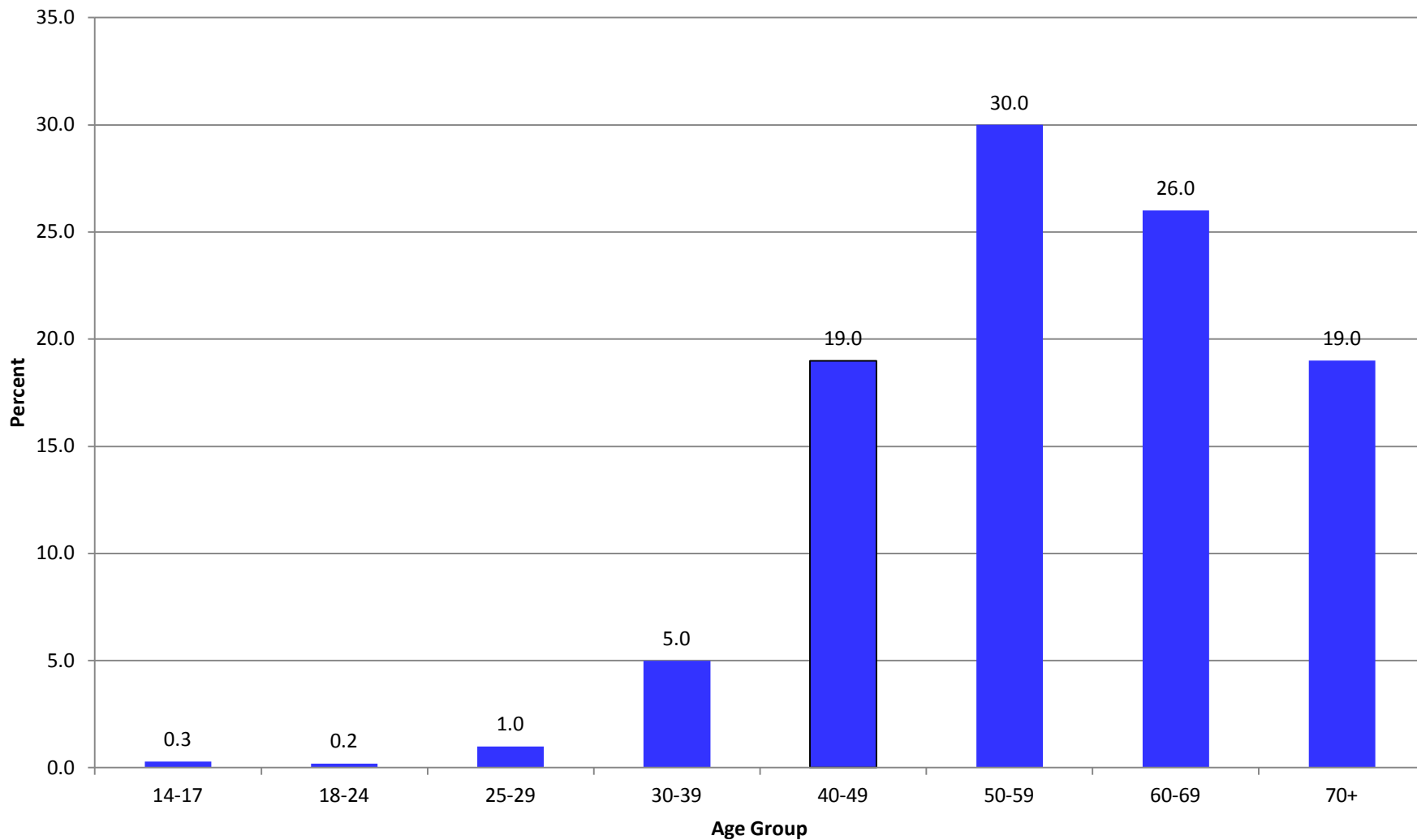


# Alcohol-caused hospital separations by age group, 2009-10



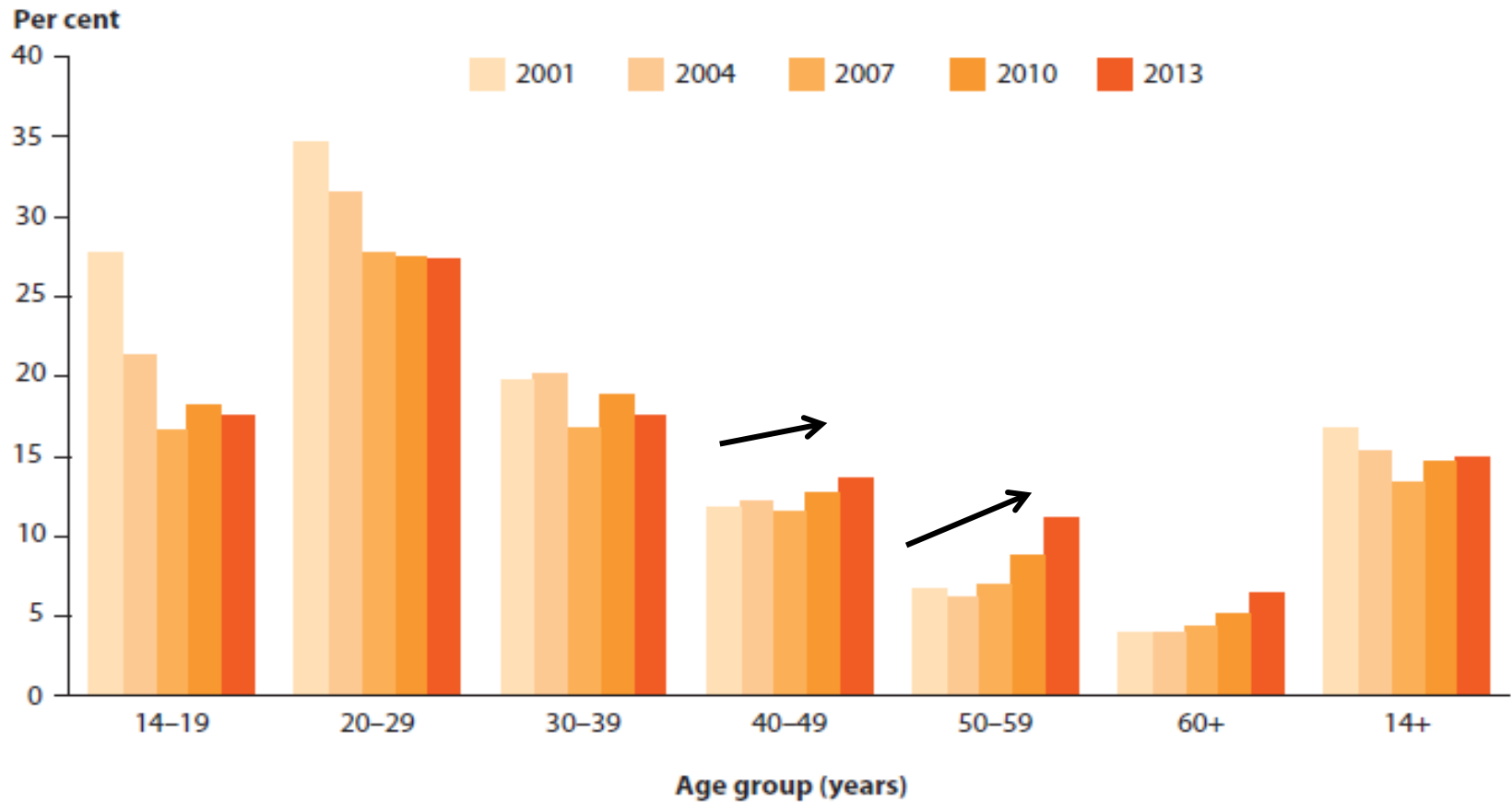
Source: Australian Institute of Health and Welfare. 2009-10 Hospital separations data (NCETA secondary analyses, 2013).

# Deaths due to alcohol-caused diseases by age group



Source: Australian Bureau of Statistics. 2010 Mortality Data (ABS secondary analyses, 2013).

# Illicit Drug Use by Age (NDSHS, 201-2013)

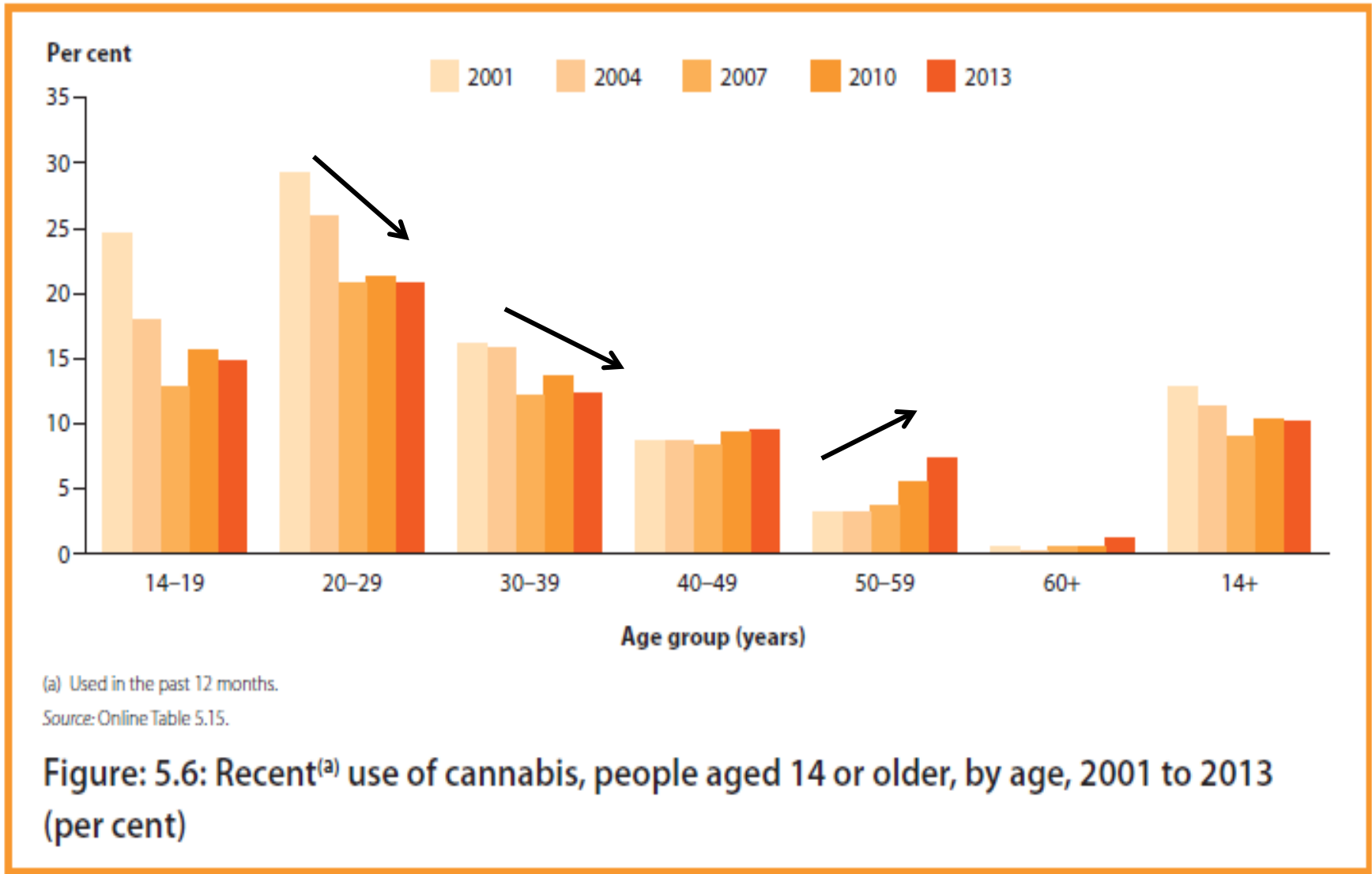


(a) Used at least 1 of 17 illicit drugs in the previous 12 months in 2013; the number and type of illicit drug used varied between 1995 and 2013.

Source: Online Table 5.6.

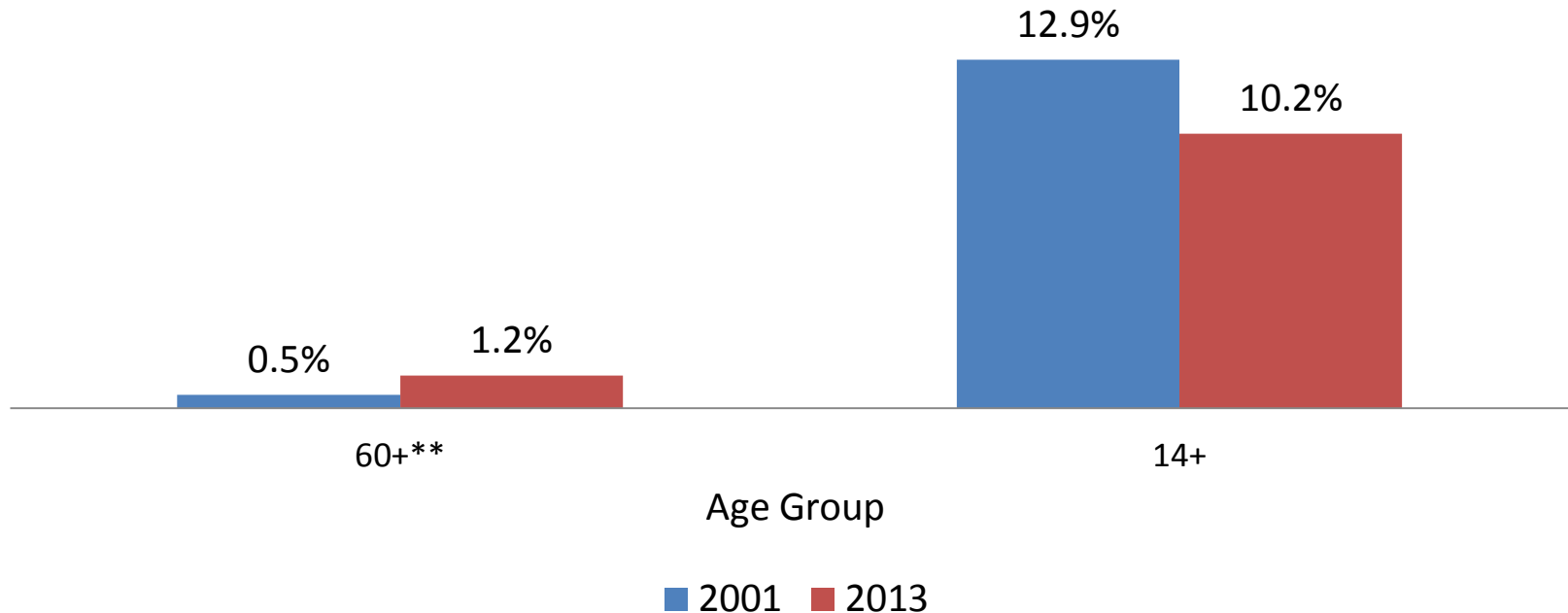
**Figure 5.4: Illicit use of any drug<sup>(a)</sup>, people aged 14 or older, by age, 2001 to 2013 (per cent)**

# Cannabis Use (NDSHS 2001 – 2013)



# Recent<sup>1</sup> Cannabis Use

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



Source: Australian Institute of Health and Welfare (AIHW).  
2001 and 2013 National Drug Strategy Household Survey  
(NCETA secondary analysis, 2015).

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

**<sup>1</sup> Used cannabis in the past 12 months.**

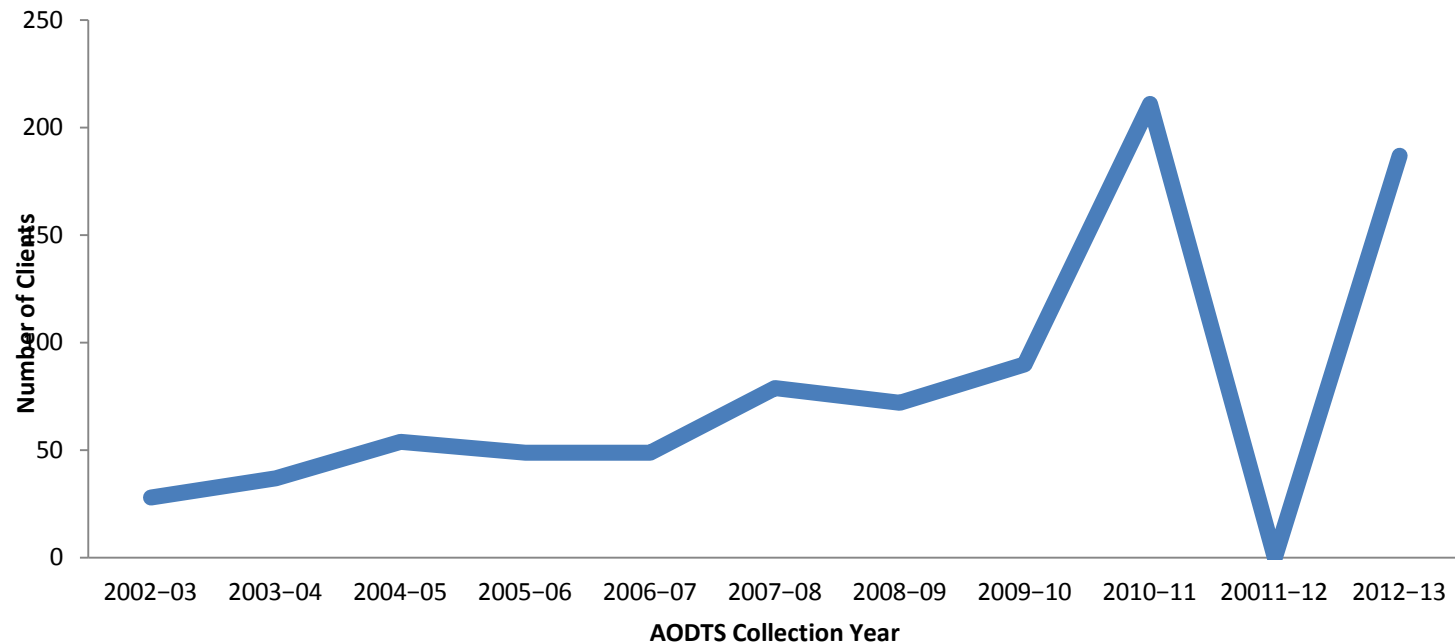
# Principal Drug of Concern: Cannabis

	2002– 03	2003– 04	2004– 05	2005– 06	2006– 07	2007– 08	2008– 09	2009– 10	2010– 11	2011– 12	2012– 13
Frequency	28	37	54	49	49	79	72	90	211	0	187
Percentage	1.16%	1.48%	1.98%	1.77%	1.68%	2.10%	1.95%	2.18%	4.71%	0%	4.0%

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**

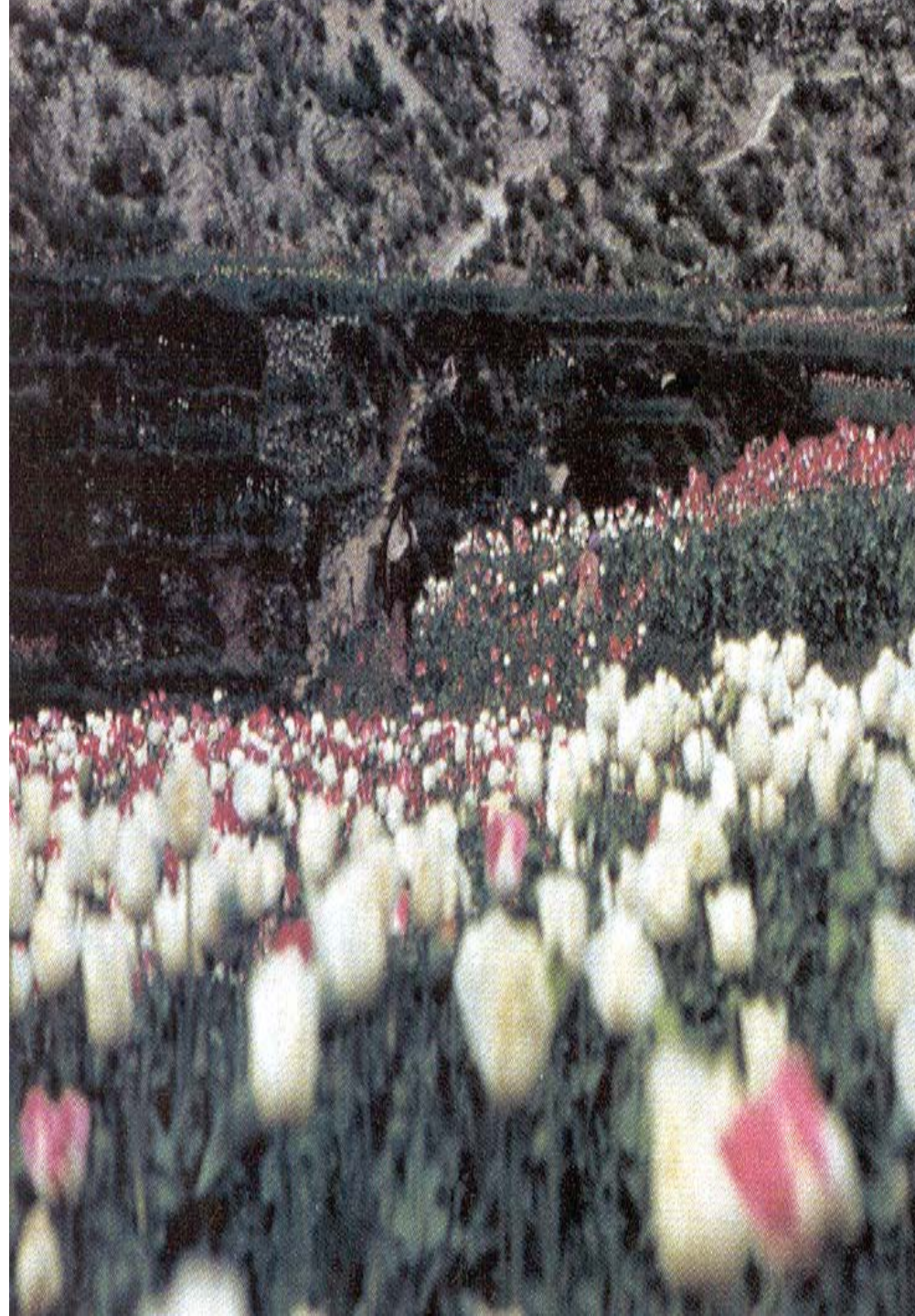


## Prescribed Opioids

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.

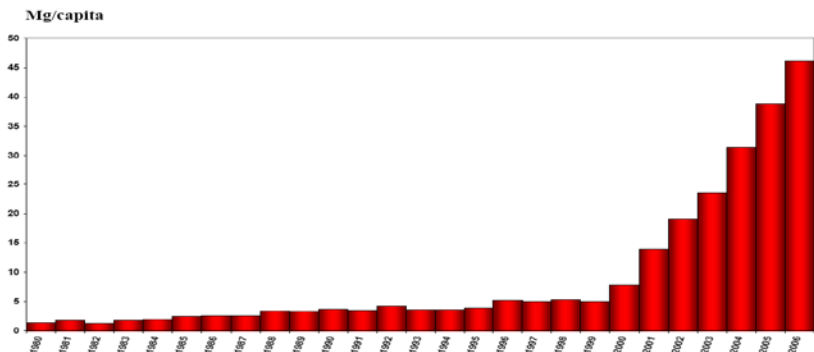
Dramatic increase in fentanyl





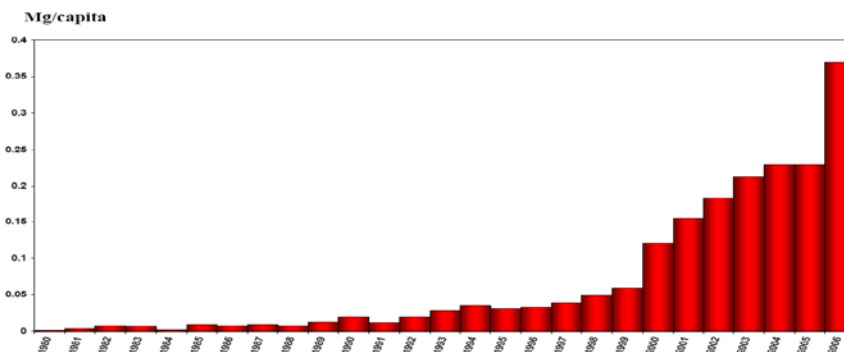
# Patterns of Opioid Use

**Mg/capita Consumption of Oxycodone, Australia, 1980-2006**



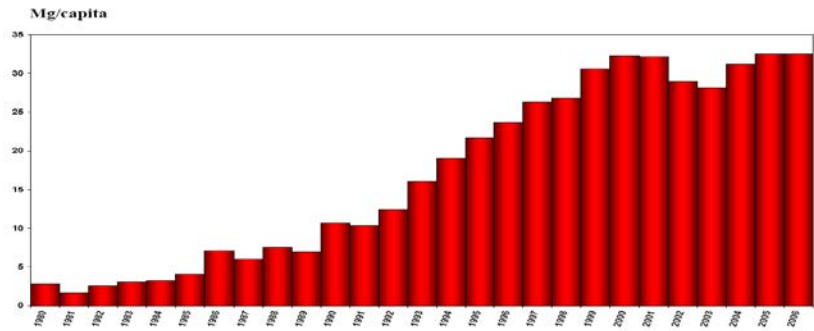
Sources: International Narcotics Control Board, United Nations population data  
By: Pain & Policy Studies Group, University of Wisconsin/WHO Collaborating Center, 2008

**Mg/capita Consumption of Fentanyl, Australia, 1980-2006**



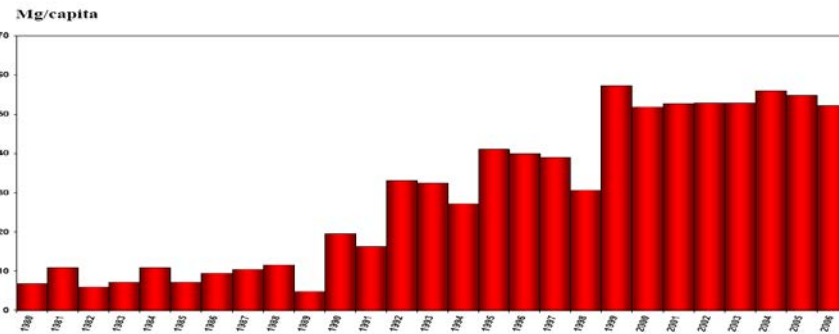
Sources: International Narcotics Control Board, United Nations population data  
By: Pain & Policy Studies Group, University of Wisconsin/WHO Collaborating Center, 2008

**Mg/capita Consumption of Methadone, Australia, 1980-2006**

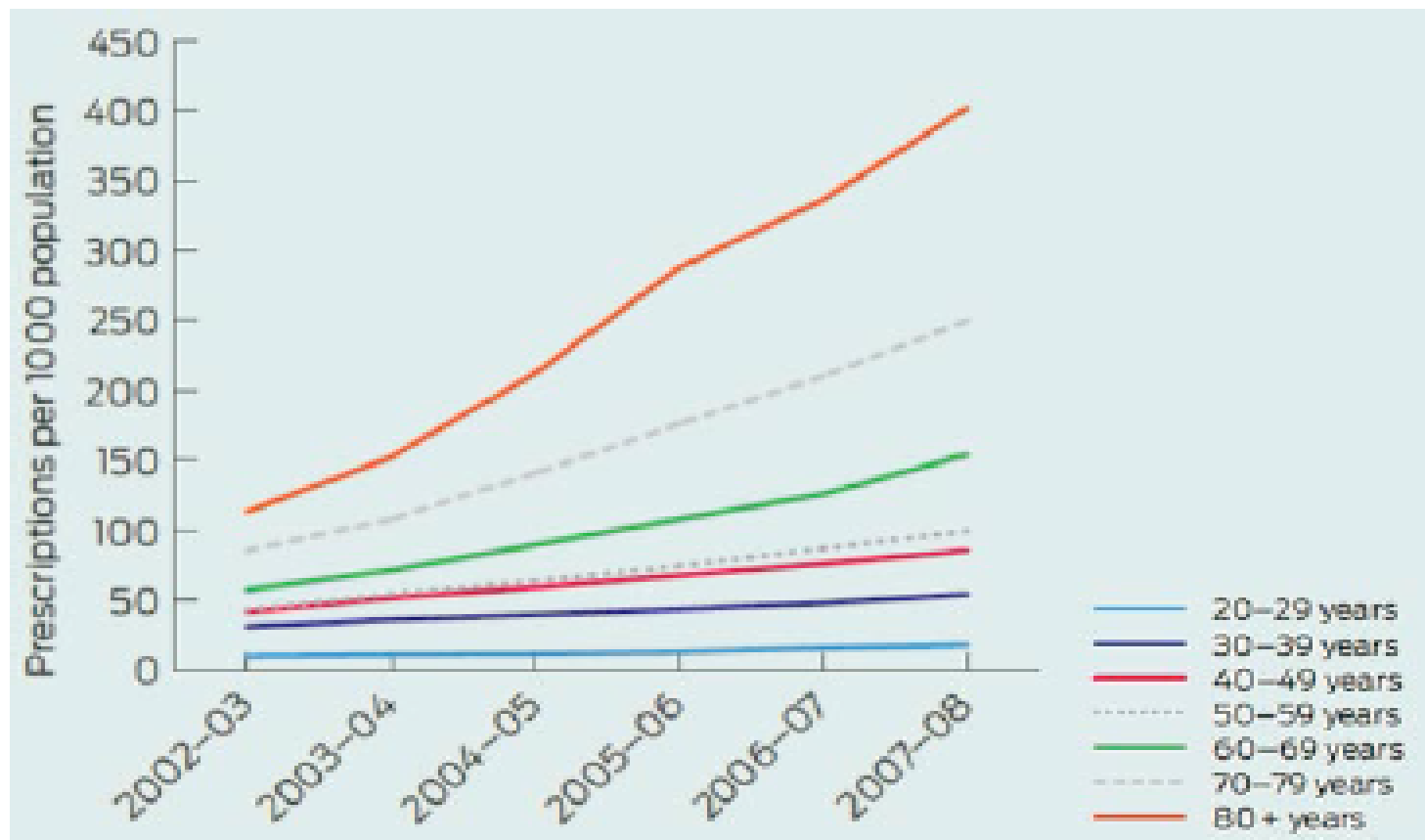


Sources: International Narcotics Control Board, United Nations population data  
By: Pain & Policy Studies Group, University of Wisconsin/WHO Collaborating Center, 2008

**Mg/capita Consumption of Morphine, Australia, 1980-2006**

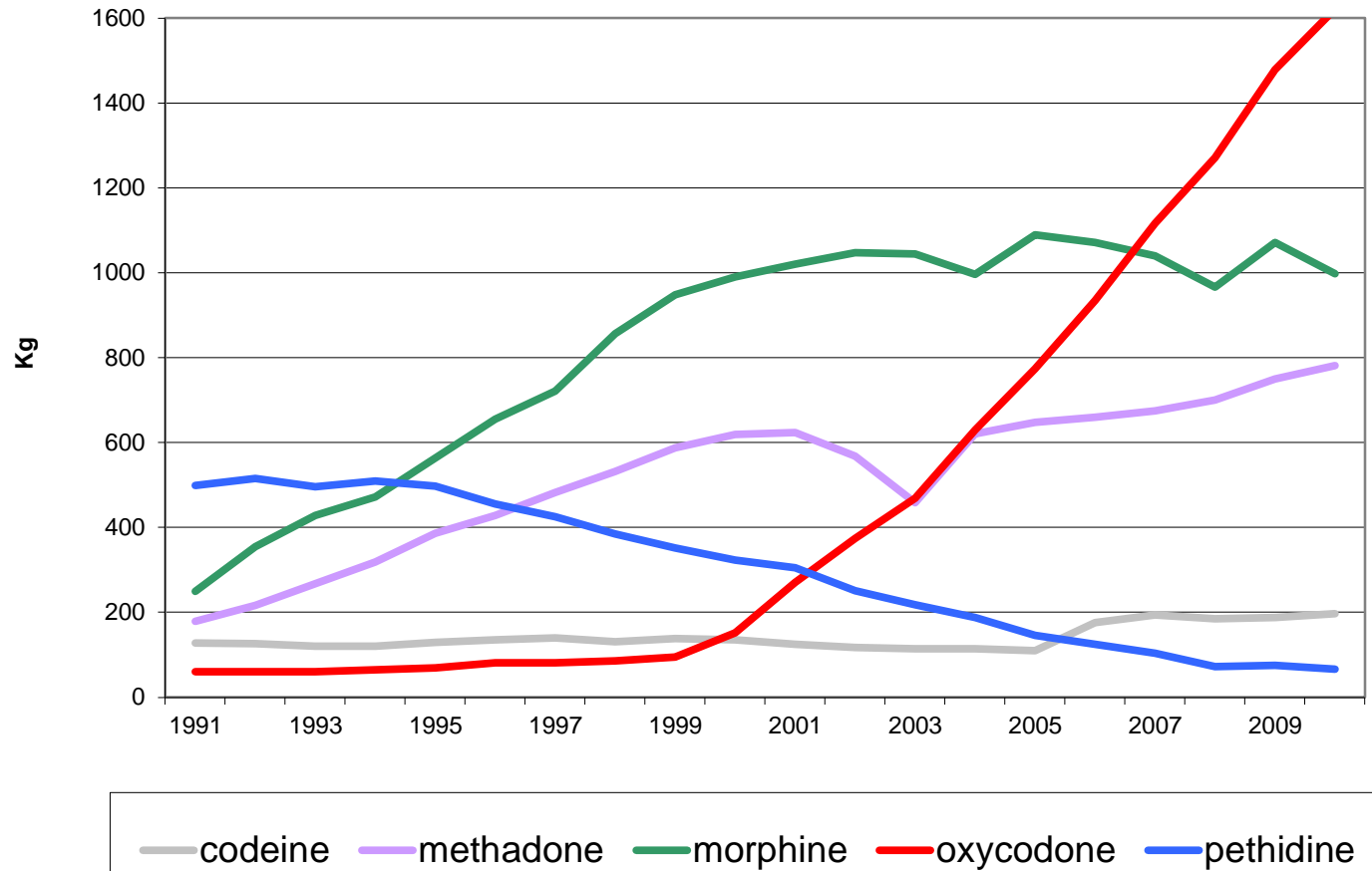


Sources: International Narcotics Control Board, United Nations population data  
By: Pain & Policy Studies Group, University of Wisconsin/WHO Collaborating Center, 2008



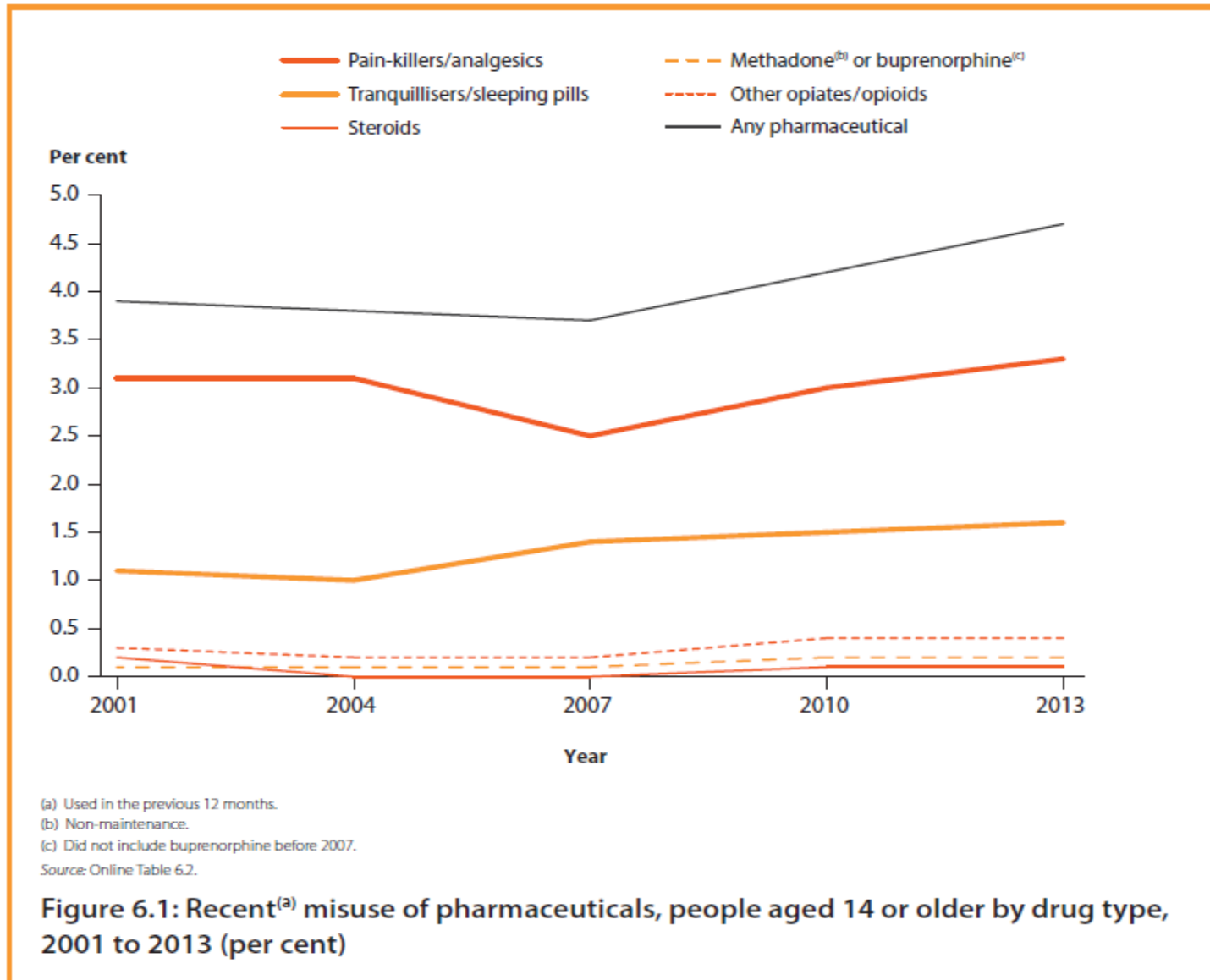
**Figure 2. Prescriptions for oxycodone dispensed on the Australian Pharmaceutical Benefits Scheme from 2002 to 2008, per thousand population, by 10-year age groups<sup>7</sup>**

## Pharmaceutical base supply: selected opioids, Australia, 1991-2010 (Dobbin, 2011)

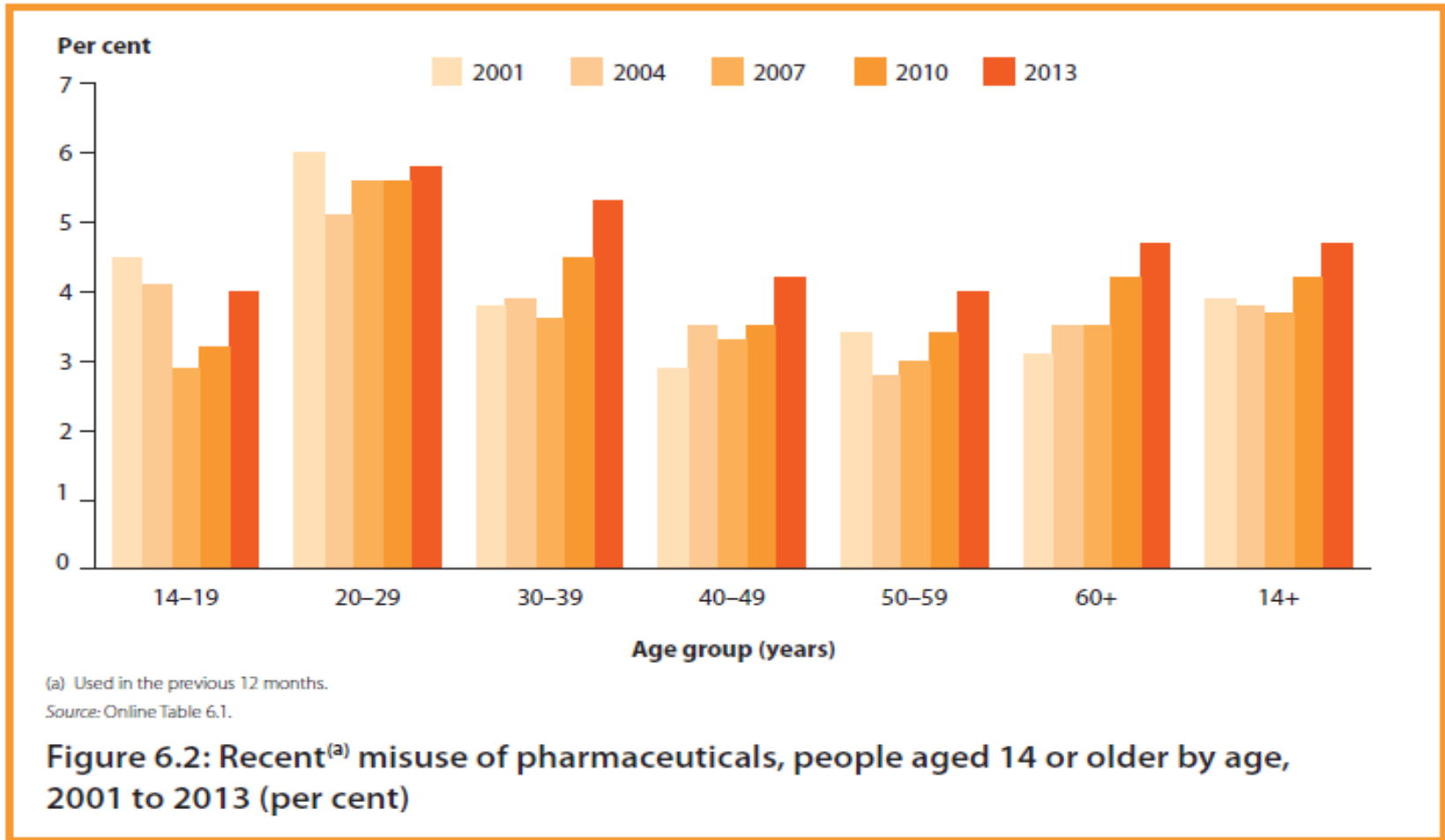


**17 fold increase in supply of oxycodone from 1999 - 2010**

# Pharmaceutical Misuse 2001 to 2013 (NDSHS)

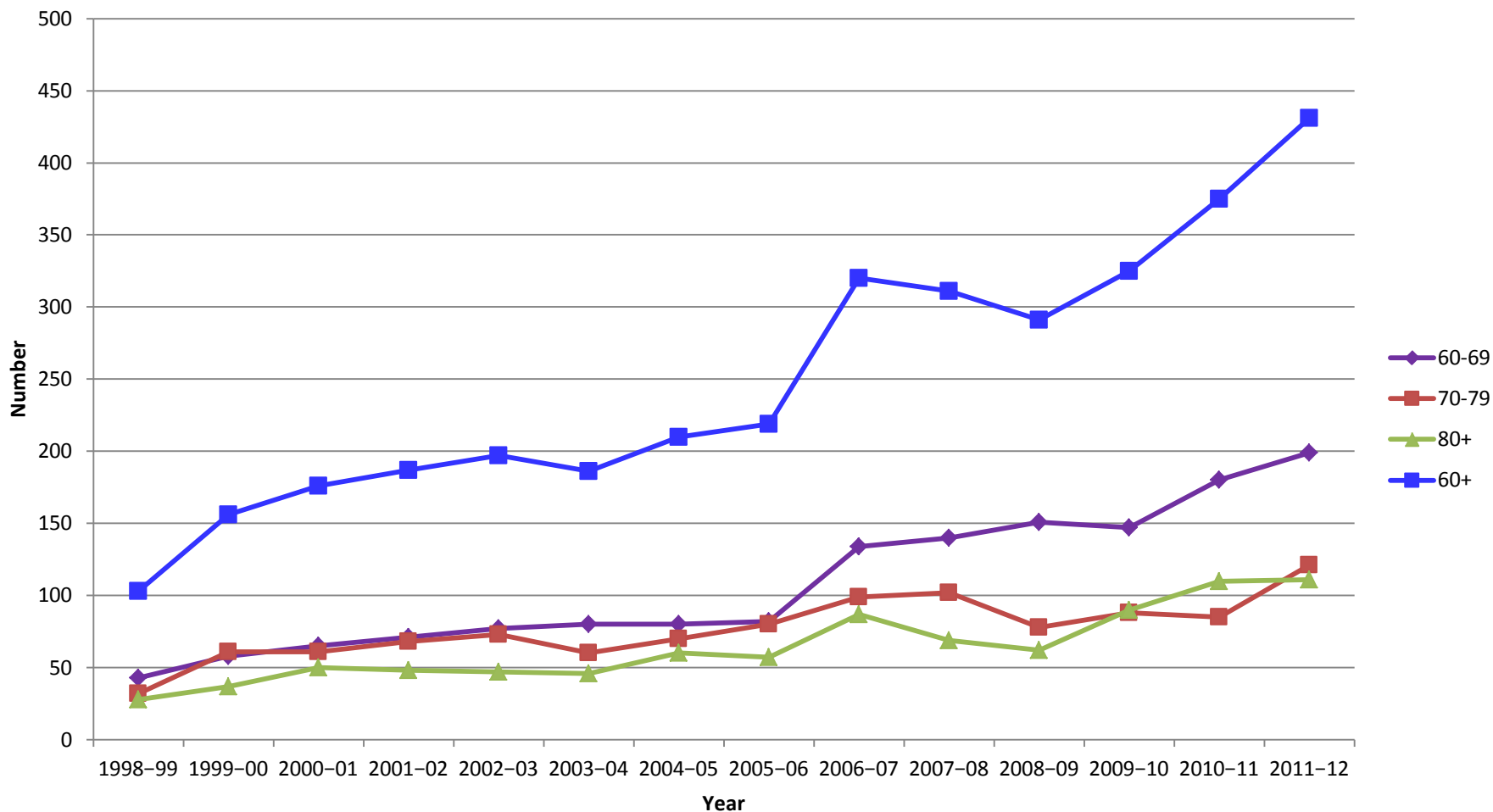


# Pharmaceutical Misuse 2001 to 2013 (NDSHS)



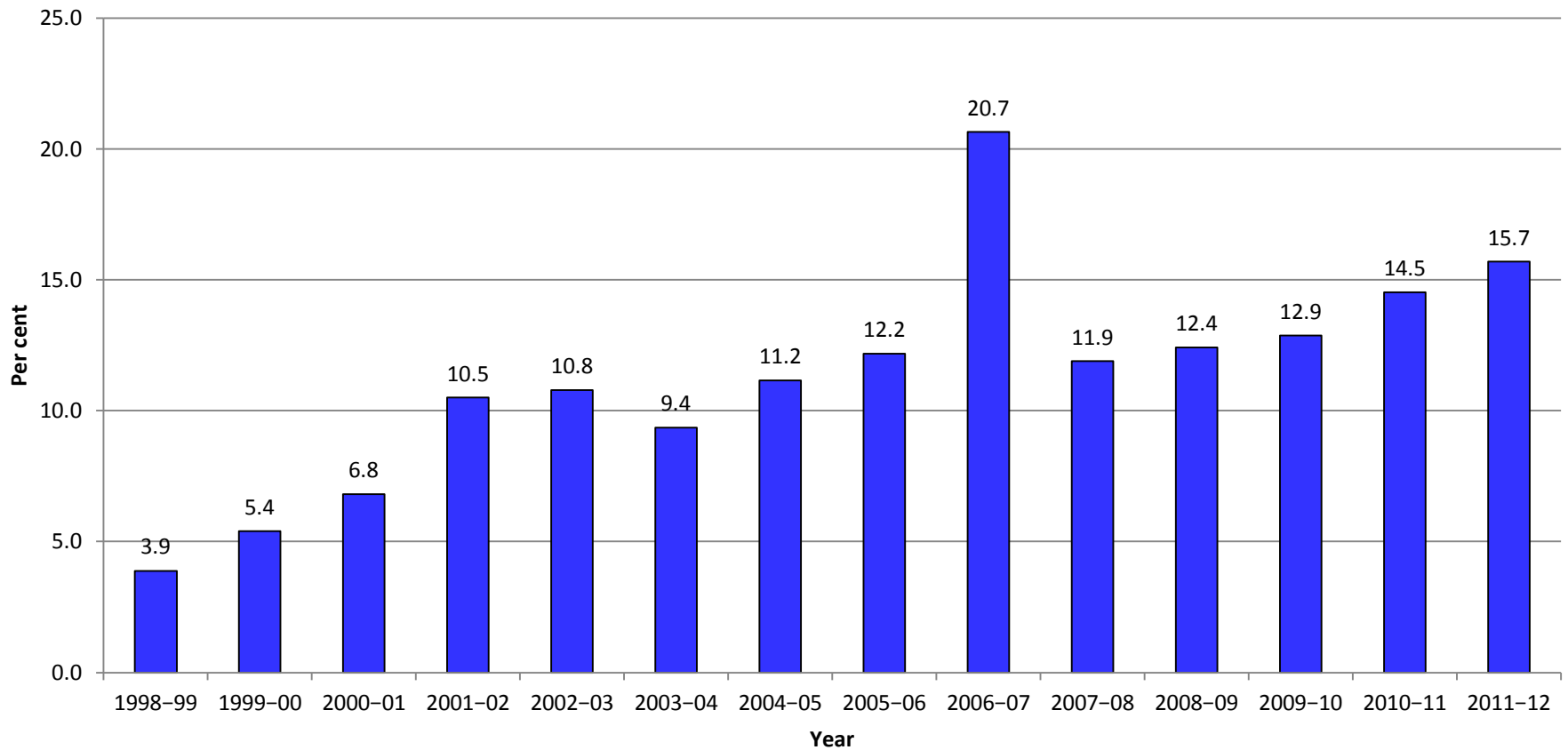


**Count of hospital separations for poisonings for heroin (T40.1), other opioids (T40.2), methadone (T40.3), and other and unspecified narcotics (T40.6), for persons aged 60+ years**



Source: Australian Institute of Health and Welfare, National Hospital Morbidity Dataset, 1998-9 – 2011-12 Datacubes (NCETA secondary analyses, 2014).

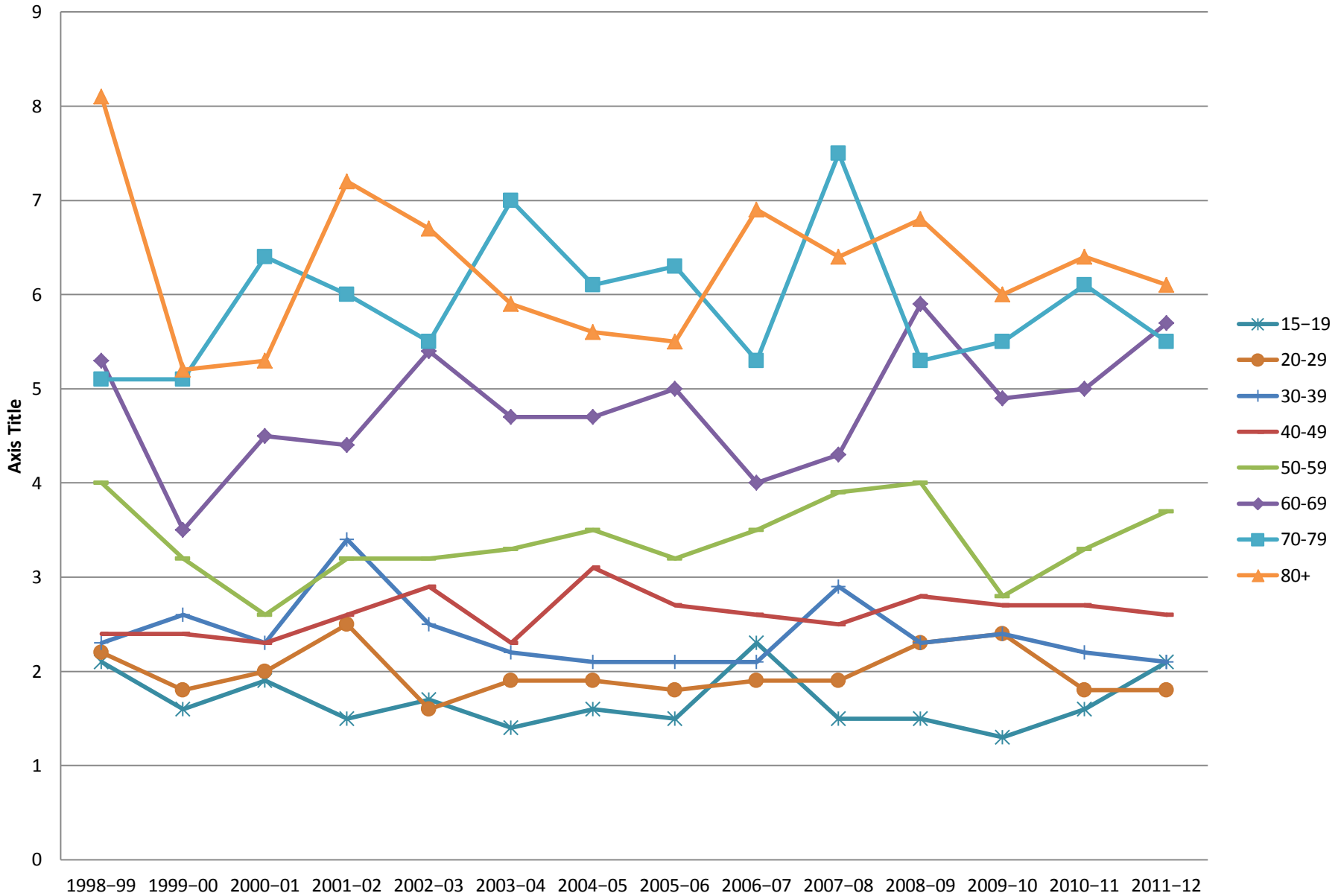
# Proportion of hospital separations for poisonings from heroin (T40.1), other opioids (T40.2), methadone (T40.3), and other and unspecified narcotics (T40.6), for persons aged 60+ years



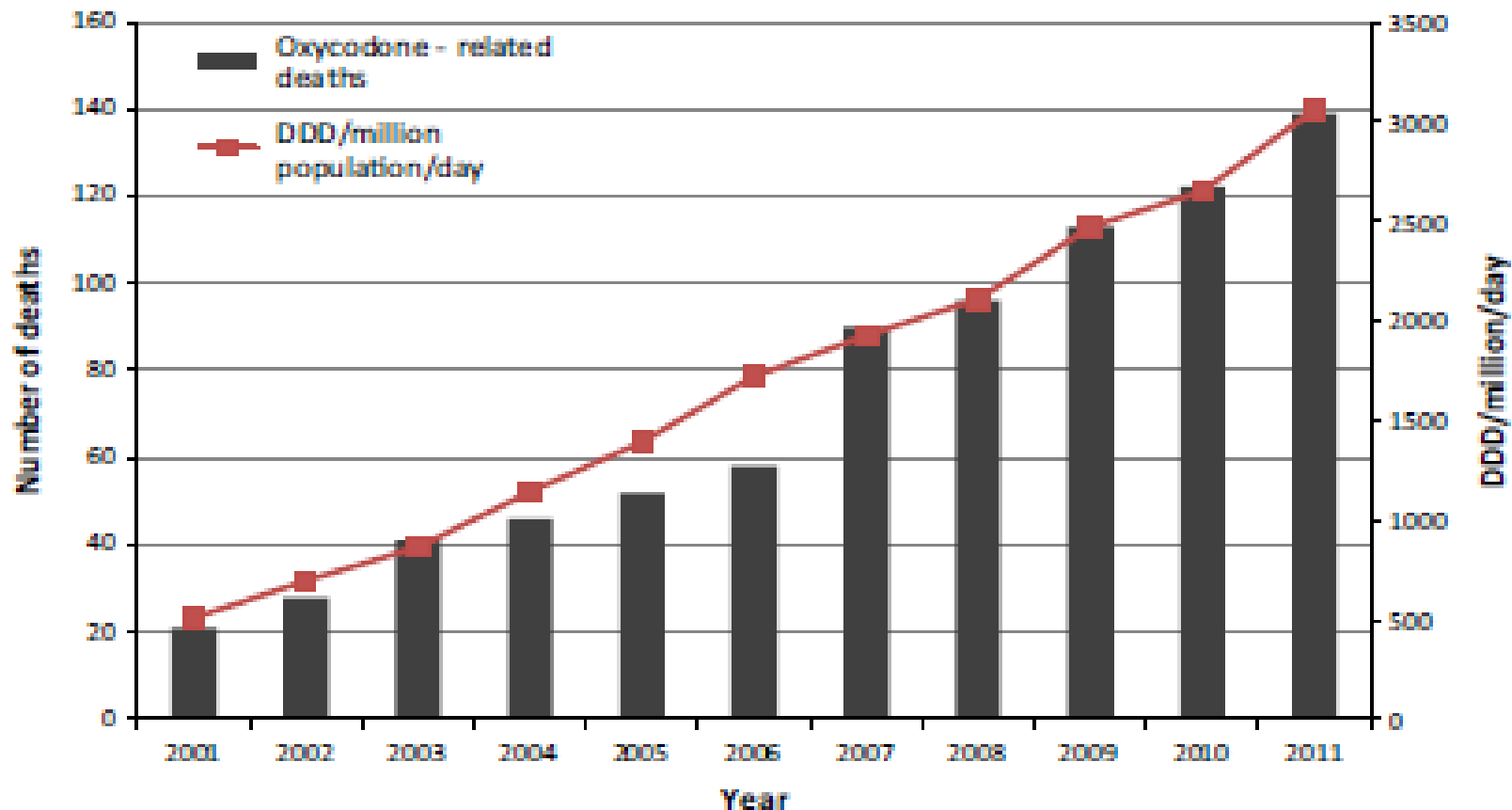
Source: Australian Institute of Health and Welfare, National Hospital Morbidity Dataset, 1998-9 – 2011-12 Datacubes (NCETA secondary analyses, 2013).



## 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)



# 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)

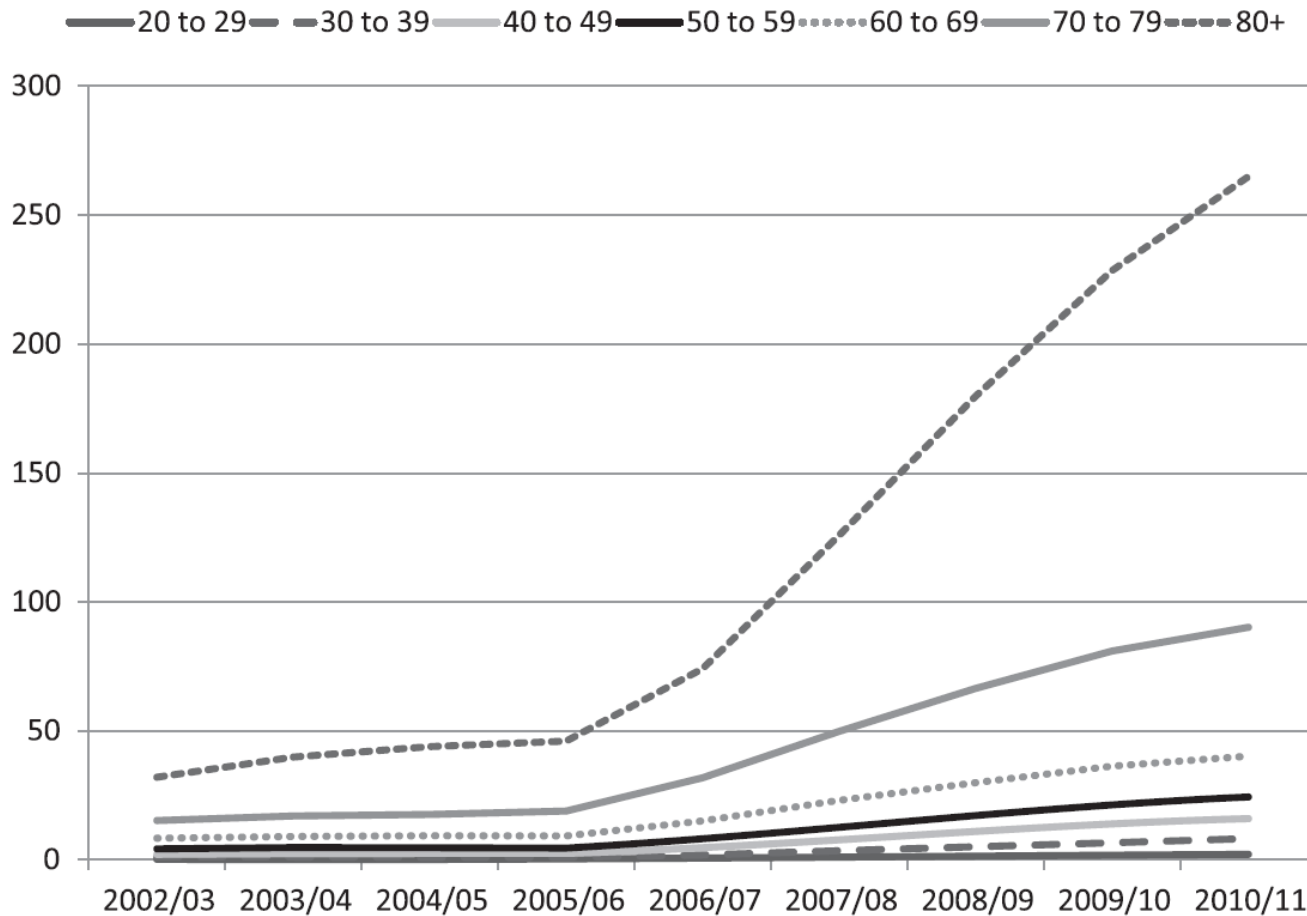


Deaths associated with oxycodone increased 7 fold in an 11 year period



# 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, Karandinos, 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])

**Proportion of clients receiving opioid pharmacotherapy  
in Australia on a snapshot day aged  $\geq 50$  years 2006-2013  
(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.

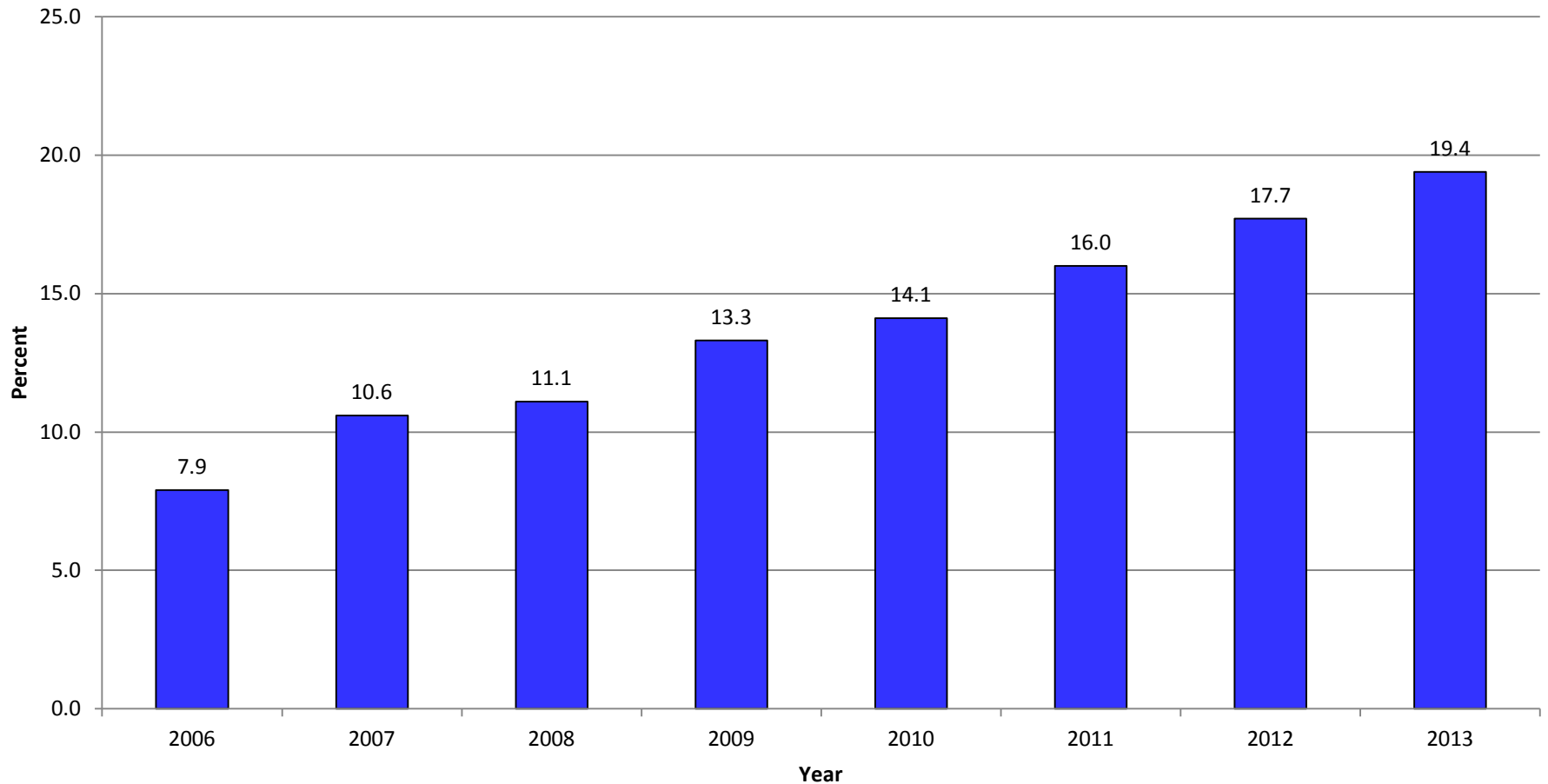
# Increasing Age of OST Clients

- 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



Source: Australian Institute of Health and Welfare 2014. National opioid pharmacotherapy statistics 2013. Drug treatment series no. 23. Cat. no. HSE 147. Canberra: AIHW.

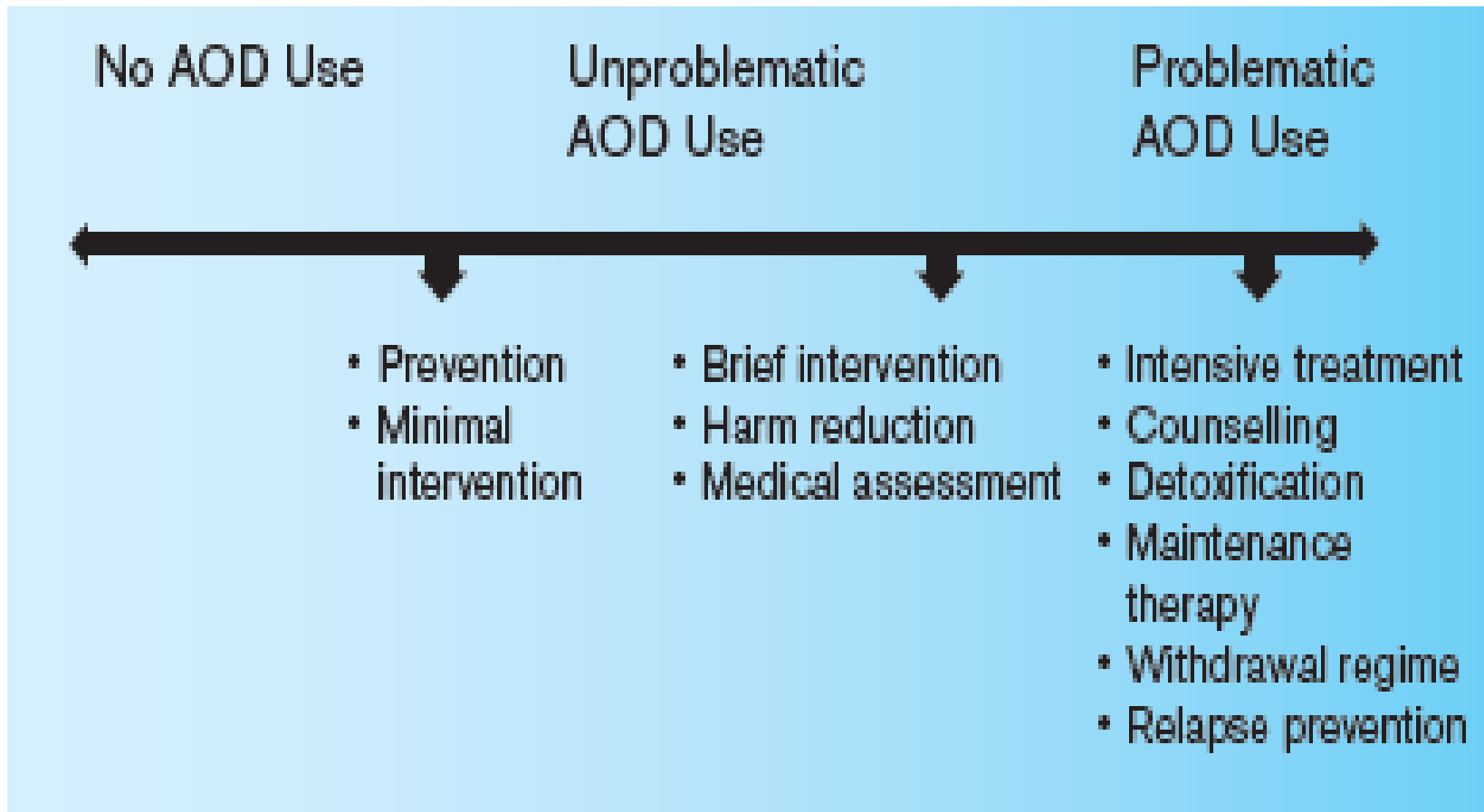
# What's Needed

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**

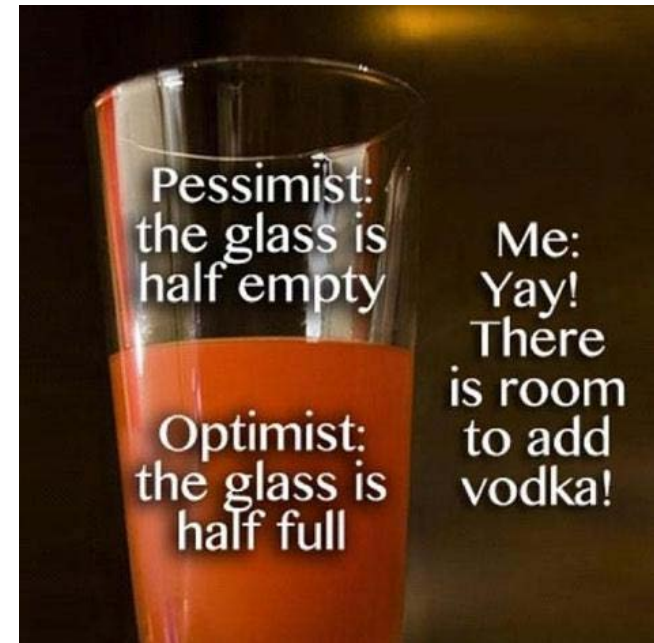
## The spectrum of alcohol and drug (AOD) problems



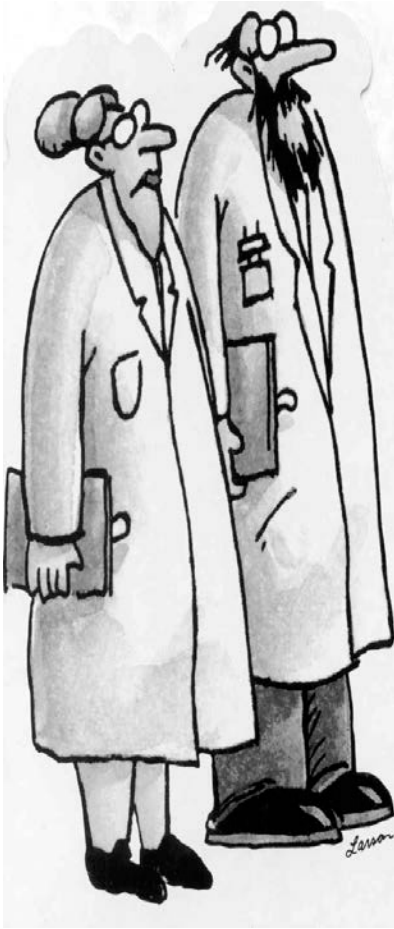
# Barriers to treatment

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?

#### 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).

### 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.

### *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.



Australia's National Research Centre  
on AOD Workforce Development

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



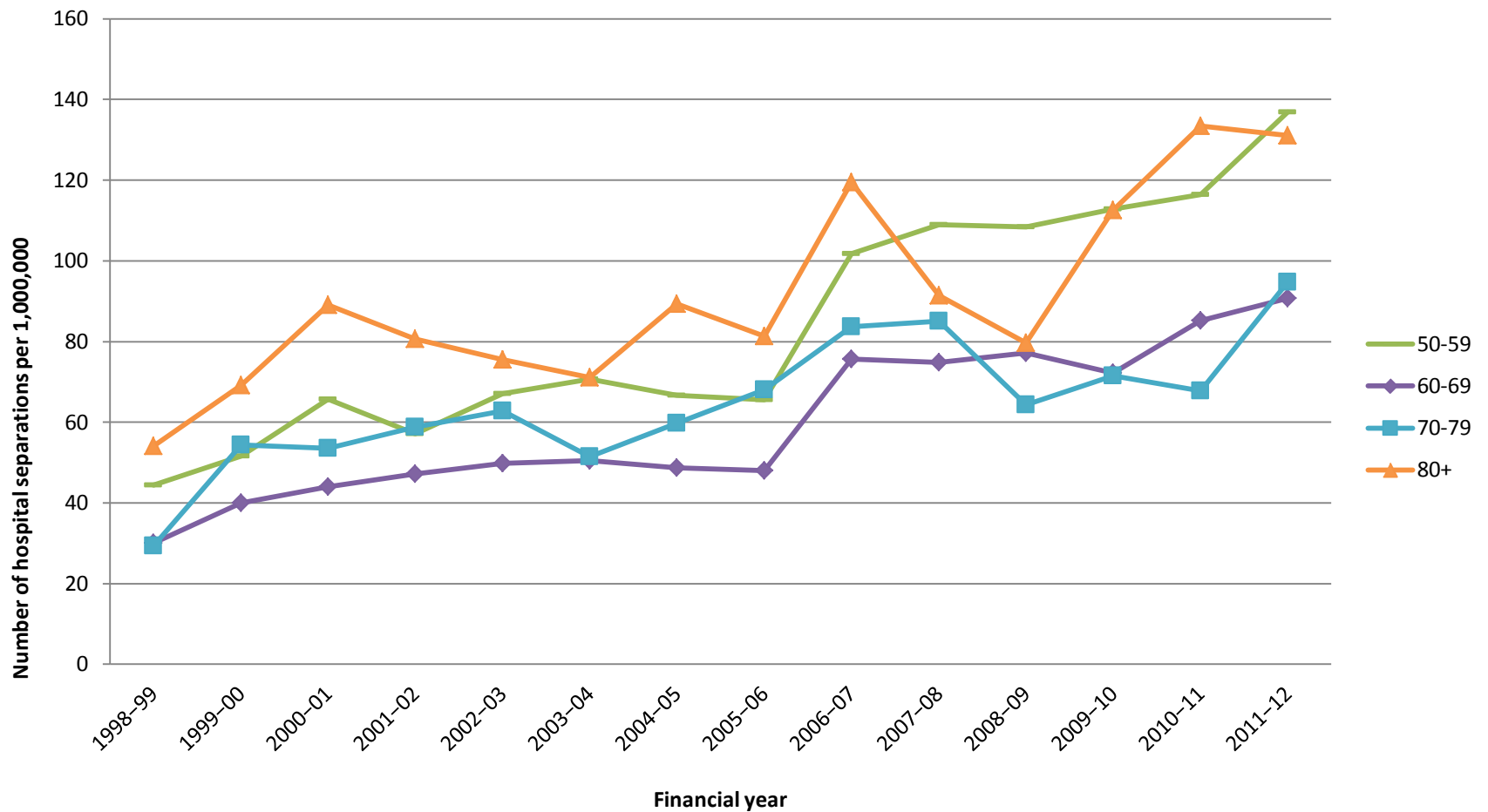
# RESULTS

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

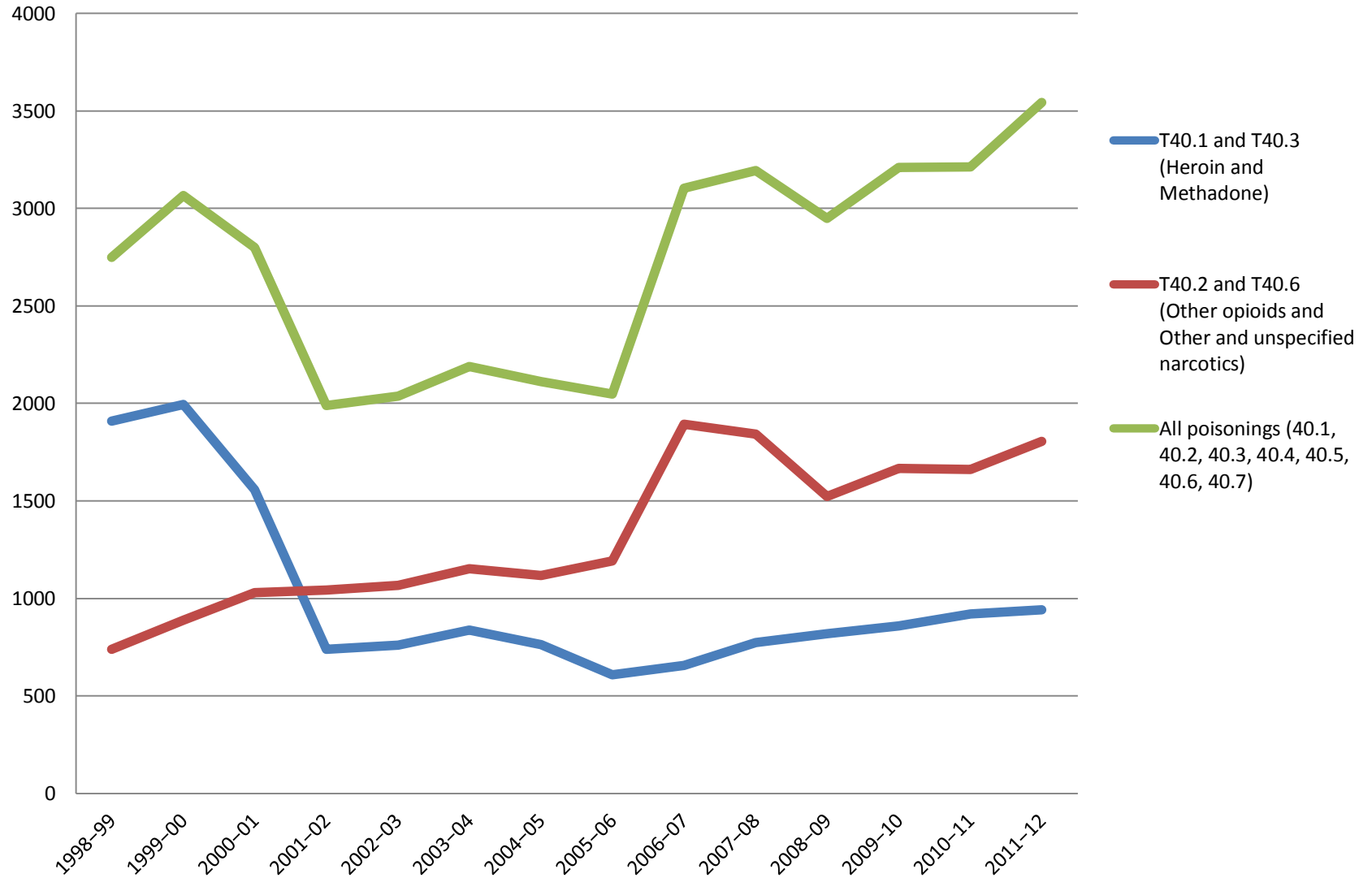
- Number of hospital separations
- Gender adjusted hospital separations
- Age adjusted hospital separations
- Average length of stay

# Australian age adjusted opioid poisoning hospital separations rate per 1,000,000 1998-99 to 2011-12

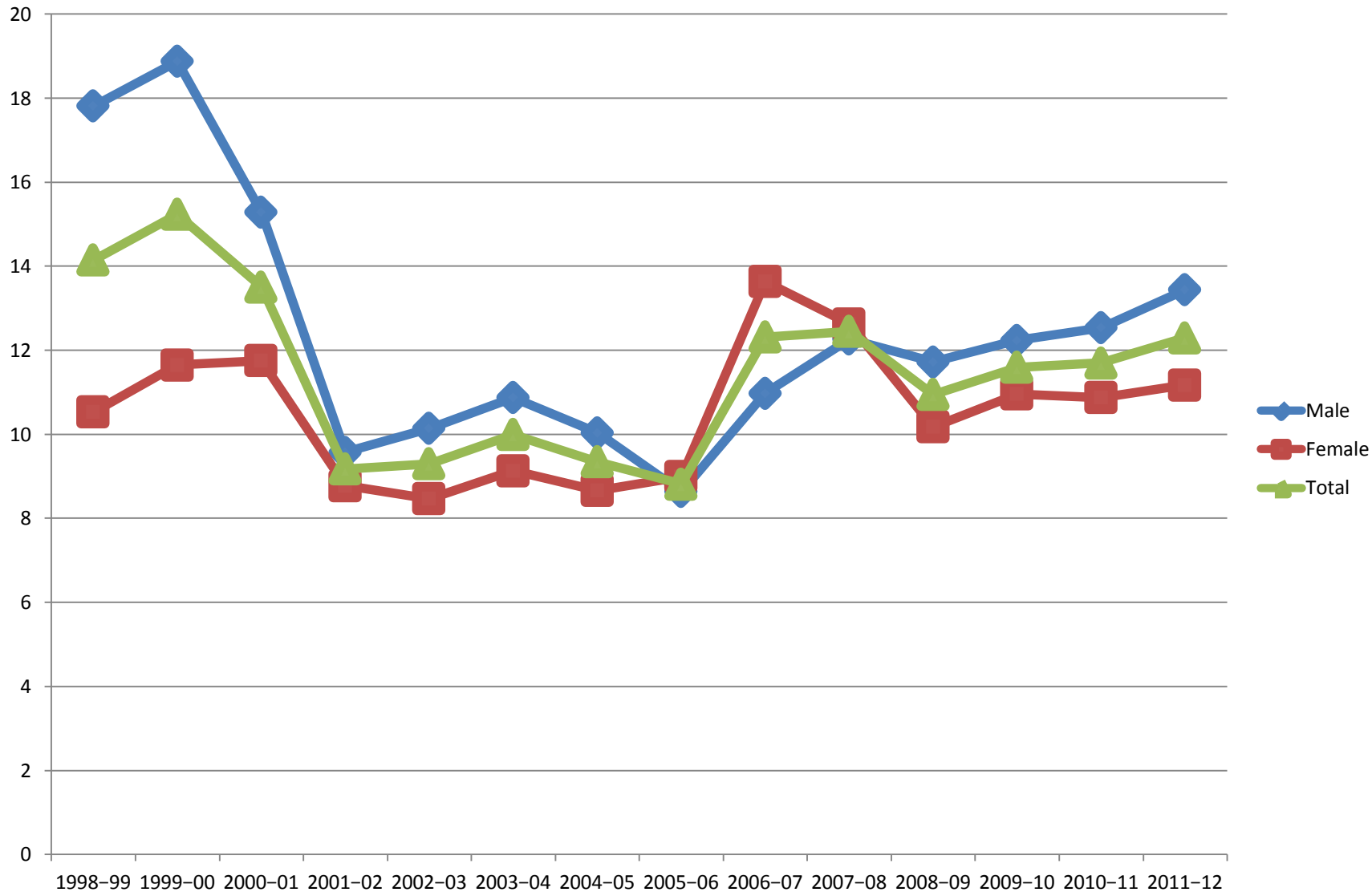
Secondary analysis of Australian Institute of Health and Welfare data undertaken by the National Centre for education and Training on Addiction, 2014)



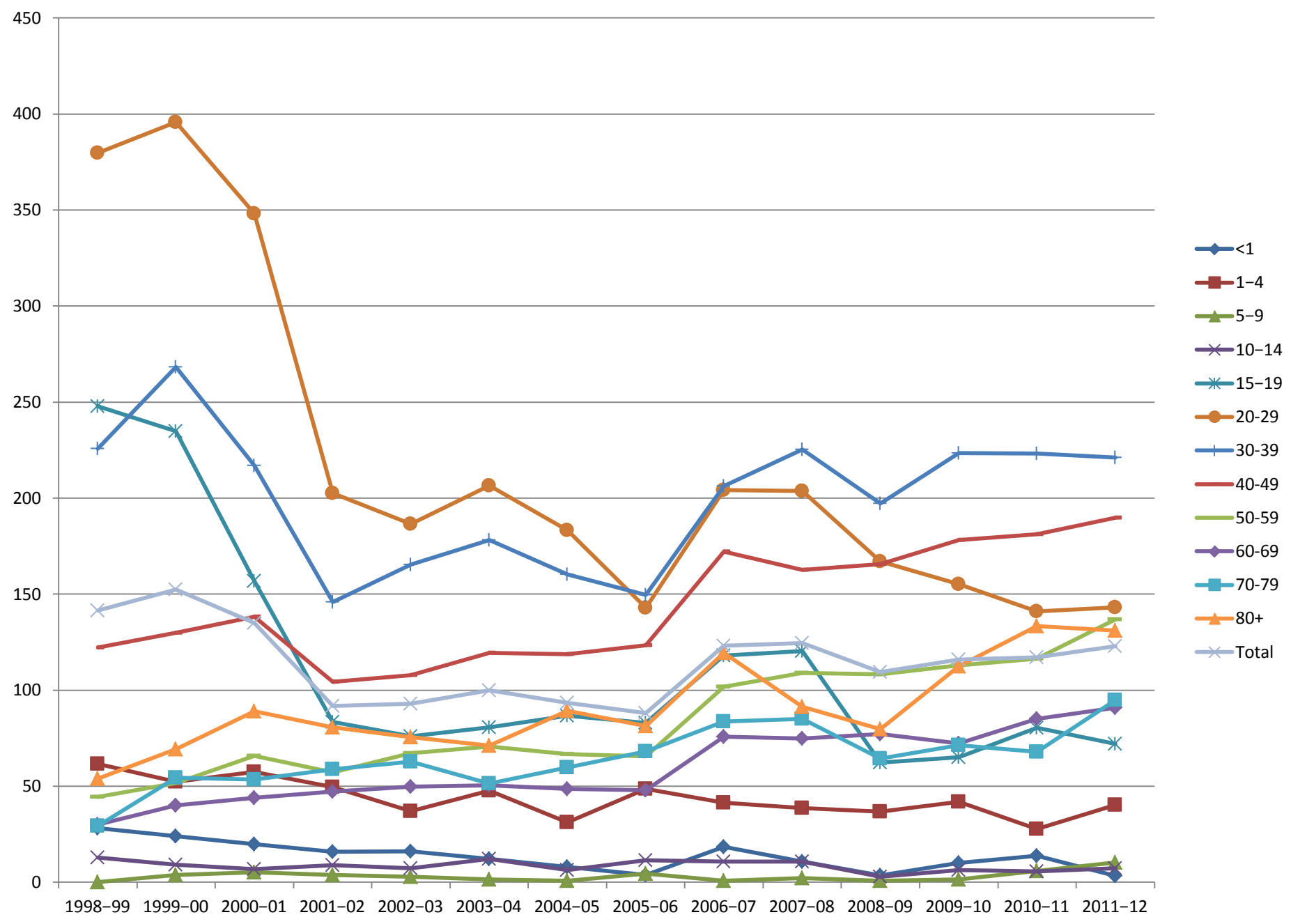
**Figure 1: Total crude hospital separations from drug-related poisonings from 1998-2011**



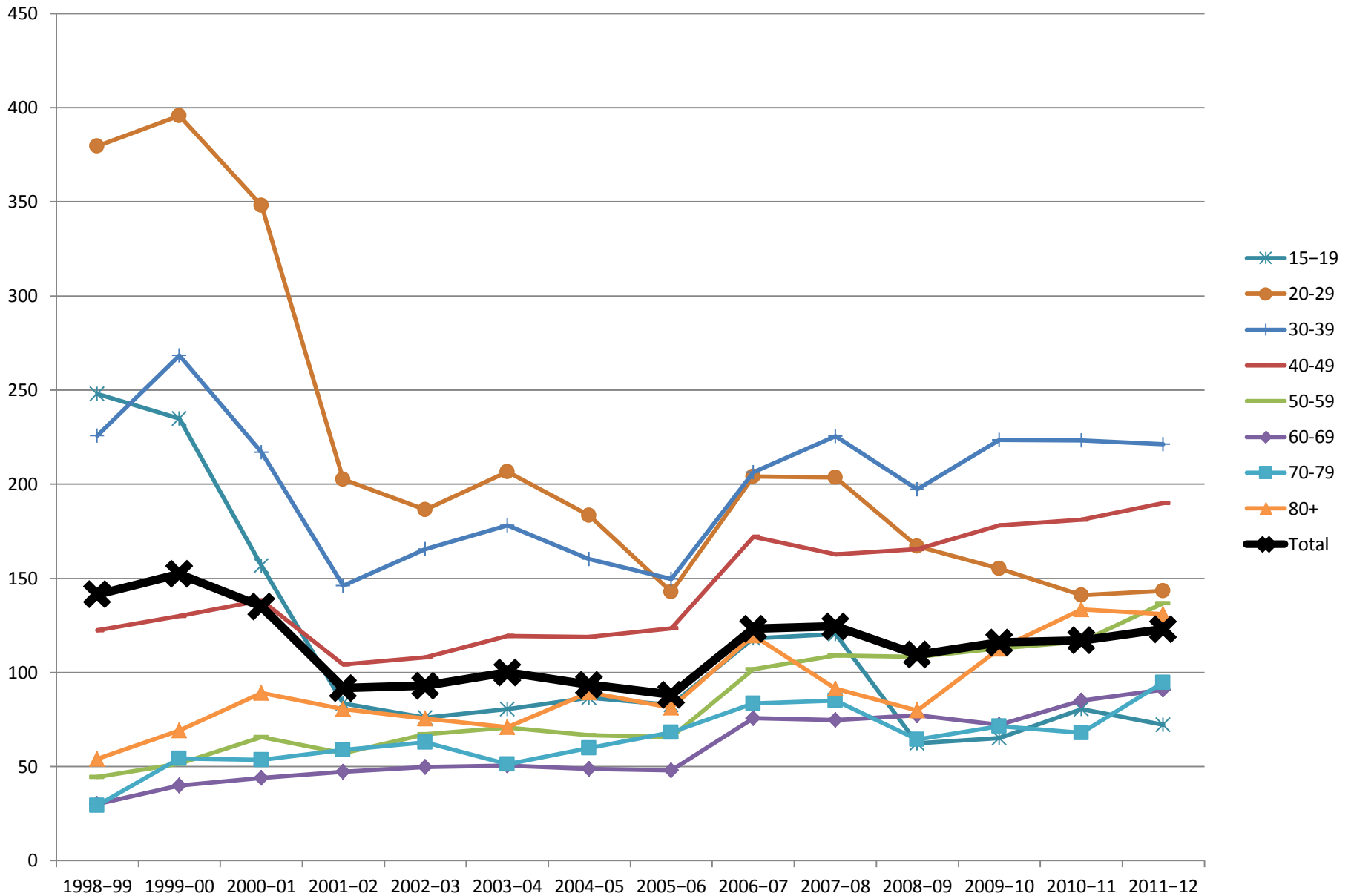
**Figure 2: Sex adjusted rate of Opioid poisoning hospital separations per 1,000,000**



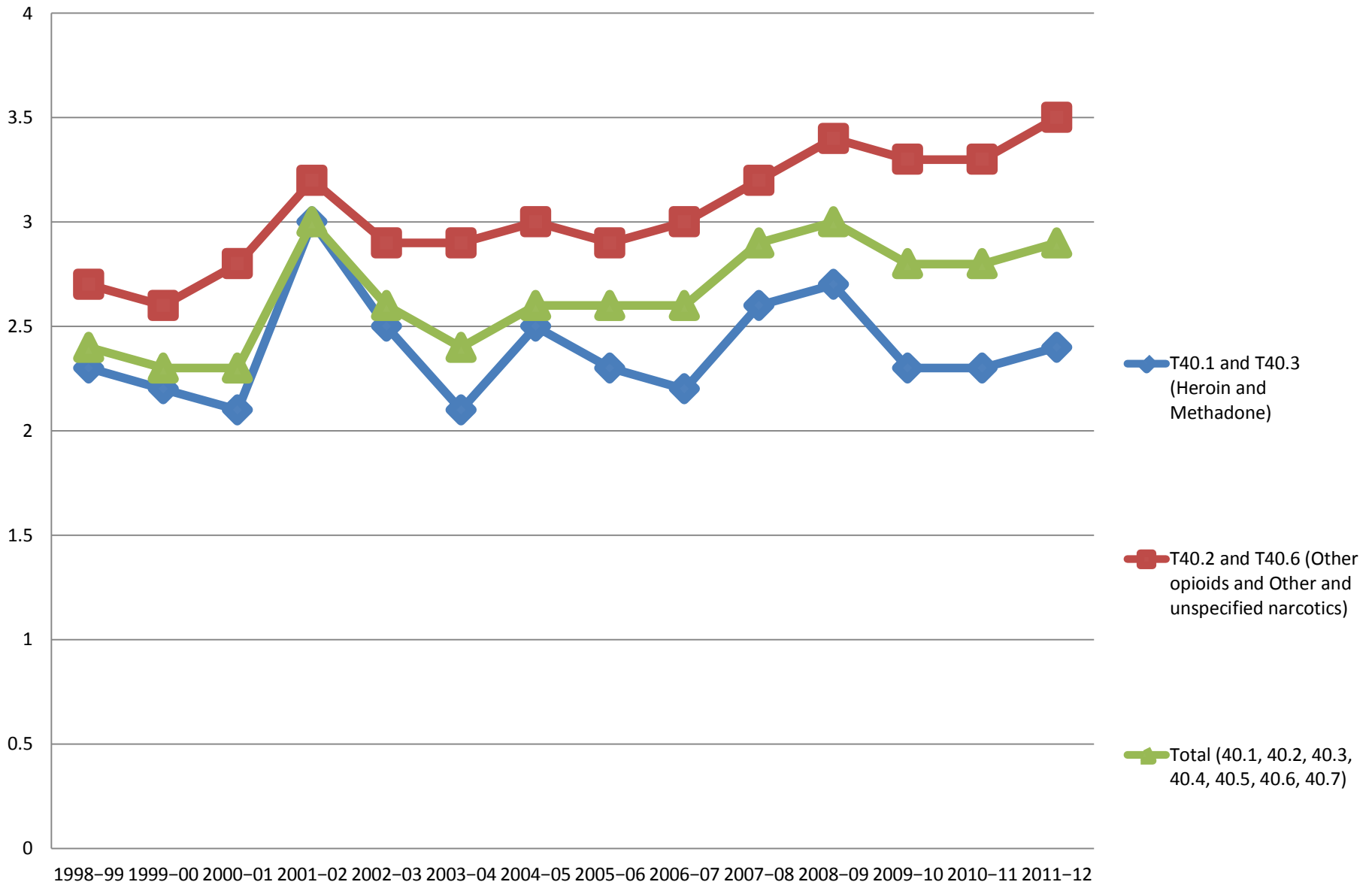
**Figure 3: Age adjusted opioid poisoning hospital separations rate per 1,000,000**



**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**



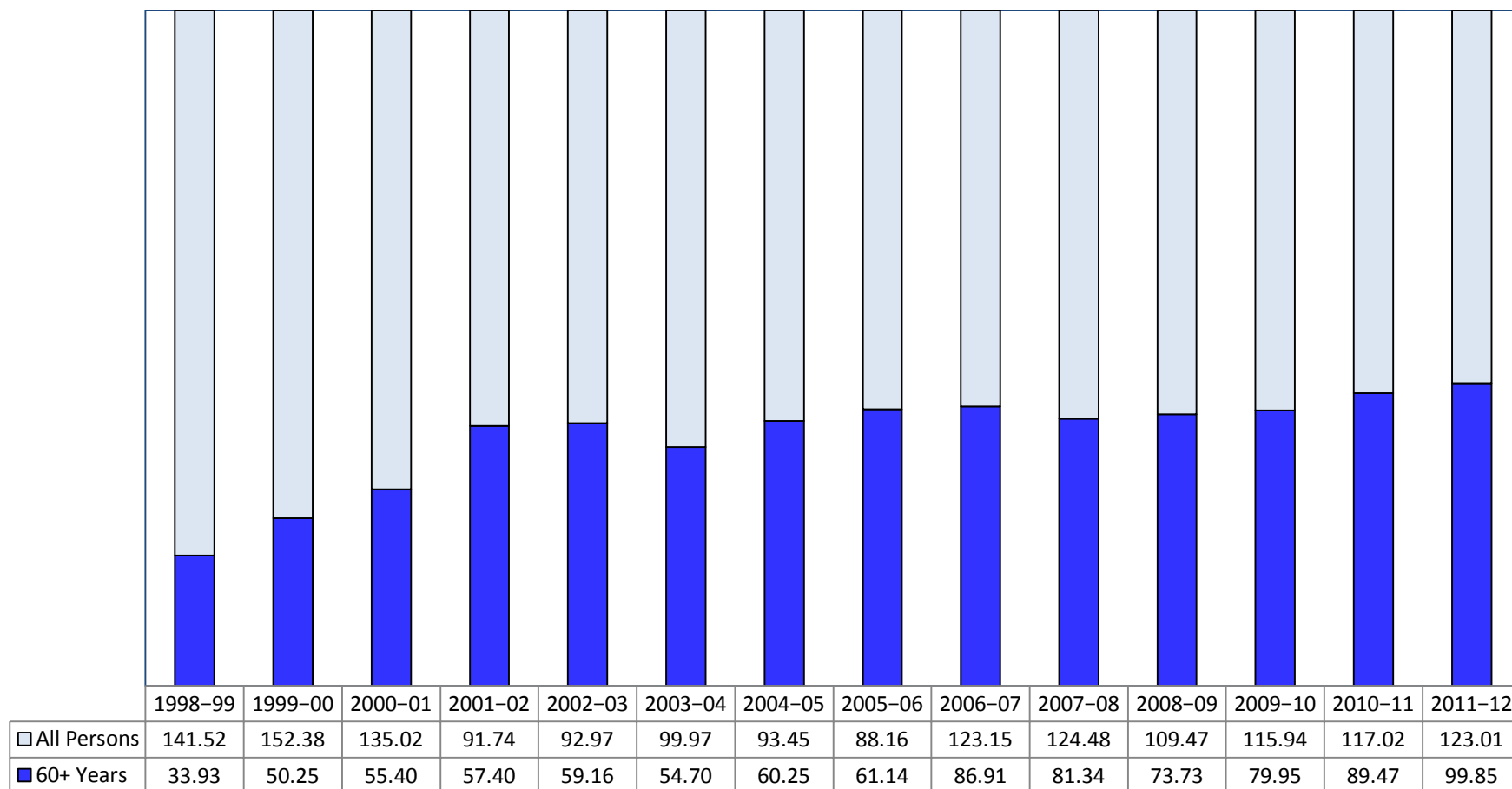
**Figure X: Age adjusted hospital separations for heroin (T40.1), other opioids (T40.2), methadone (T40.3), and other and unspecified narcotics (T40.6), for persons aged 60+ years (per 1,000,000)**



Source: Australian Institute of Health and Welfare, National Hospital Morbidity Dataset, 1998-9 – 2011-12 Datacubes (NCETA secondary analyses, 2013).



**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)**



Source: Australian Institute of Health and Welfare, National Hospital Morbidity Dataset, 1998-9 – 2011-12 Datacubes (NCETA secondary analyses, 2013).