Responding to older AOD users

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Victoria’s ageing population is growing. It consumes a large array of prescription medication as well as alcohol and other drugs. In large part substance misuse issues for the older population are pervasive yet silent, as many of the symptoms and harms are being subsumed and attributed to the normal ageing process. Further, many older people do not present to drug treatment services and therefore do not identify with having a substance dependence problem. This is costing the community, both financially and socially through an increase in preventable harm. There is an urgent need to bolster the alcohol and other drug sector to ensure that it can cater for the burgeoning ageing population and the complex and unique challenges which it presents, and develop service systems which increase accessibility.

The ageing population

The ageing of the population represents a major transformation of Australian society and presents significant challenges for social, health and economic policy and program planning.

The Australian Bureau of Statistics (ABS) estimates that the proportion of Australians aged over 65 will increase from around 13 per cent in 2007, to around 23 to 25 per cent by 2056, and between 25 per cent and 28 per cent by 2101 (ABS 2008).

In Victoria the rate of population ageing will be most marked in outer metropolitan and rural and regional areas. Regional Victoria already has a larger older population than Melbourne and this is projected to continue.

Given the anticipated population growth of people over 50 years of age, it should be noted that currently, morbidity due to preventable chronic disease occurs most frequently to those aged between 65 to 74 years of age while those aged between 55 to 64 contributed to the highest level of potential years of life lost (PYLL) (Australian Institute of Health and Welfare 2010:10).

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1 Due to the number of studies sourced for this paper, we have not set a definitive age for older people. For instance, some studies refer to older people as being over 60, others 65 years of age or over. Therefore, in order to utilise widest breadth of material, an arbitrary age defining ‘older people’ has not been nominated.

2 PYLL is an indicator of premature death which takes account of deaths which occur prior to a certain age.
Many preventable chronic diseases are exacerbated by substance use. Service system changes will need to occur both within the AOD sector and broader health system as a means to reduce preventable harm and morbidity within the ageing population.

Costs associated with AOD use amongst older people has to date attracted very little attention. It would appear that older AOD users tend not to approach AOD treatment services, with those over 65 years of age accounting for just 2 per cent of all completed courses of treatment for alcohol and 2 per cent of all completed courses of treatment for benzodiazepines in 2005-06 (Department of Health 2009:48, 117). Given that people over 65 years of age made up 13.6 per cent of the Victorian population in 2009, the treatment figures are very low (ABS 2009).

In many instances the underlying substance use issues of older people may go unrecognised. VAADA believes action should be taken now to plan and ensure that the AOD service system is equipped to respond to the needs of Victorians as they age. This requires maximising knowledge about the issues, and access to specialist services.

A useful way of assessing need and providing a ready means of service access is to establish a pilot older persons AOD treatment program in a demographically suitable region. Suitable program and demand evaluation should be undertaken.

AOD use among older people

Older people use alcohol and drugs in a variety of ways. They are the largest consumers of prescribed medications (Swift, Stollznow and Pirotta 2007:529) which they take for a range of physical and psychological conditions; they smoke cigarettes, drink alcohol and use illicit substances (Crome and Crome 2005:343). Older people are more likely than younger people to be taking licit drugs and inadvertently mixing various pharmaceuticals with alcohol (Hunter and Lubman 2010:738-9). Further, due to a higher prevalence in experiencing pain, older people are more likely to be using pain reduction medication. The Royal Australasian College of Physicians (2008:48) notes that there are significant challenges with pain management and older people. There is an increase in the proportion of people who suffer chronic pain from the age of 55 years and onwards; this is likely to become more profound as this population ages (with the emergence of baby boomers into this cohort) and more problematic given the previously mentioned estimates on the growth of the aged population (Nicholas, Lee and Roche 2011:81-2). There is a clear need to adequately plan to ensure that high quality pain management services can cater for a growing ageing population and are not reliant on opioid prescribing as the sole panacea.

Older people are at risk of developing substance use issues through a complex interplay of factors. These include physiological changes, increased isolation, transitional periods such as retirement and experiences of loss and grief. Australians aged over 60 are most likely to drink daily (Australian Institute of Health and Welfare 2008:32) and some studies suggest that older people may underestimate their alcohol intake (Mehta et al 2006:1050).

It has also been suggested that differences between generational cohorts rather than age alone accounts for some drug use in older people. For instance, it has been suggested that as the ‘baby boomers’ age, they may take established substance use attitudes and behaviours into older age.
The harms from AOD use in older people

There is a large body of evidence pointing to the harms associated with short-term and long-term alcohol misuse, including liver damage, stroke, alcohol-related brain injury, coronary disease, a range of cancers, and amongst older people especially, the risk of falls.

For older people, who may have consumed alcohol at risky levels for years, these harms are further exacerbated by the decreasing tolerance for alcohol brought about by age, as well as increased severity of withdrawal symptoms (Swift et al 2007:529). Older adults are also more likely to be taking various prescribed medications which may often have adverse health reactions with alcohol, with moderate drinkers at a 24 per cent higher risk of an adverse drug reaction when compared with non-drinkers (Swift et al 2007:529).

Benzodiazepine and other tranquilliser use can greatly reduce quality of life and contribute to incontinence, confusion, lack of mobility, falls, instability and a range of other problems (Drugs and Crime Prevention Committee 2006:18-9).

Older heroin users appear less likely than younger users to reduce or cease heroin use at times of limited supply, but when they do, appear more likely to engage in other risky drug using activities such as benzodiazepines injecting (National Drug and Alcohol Research Centre 2004).

These harms may be further exacerbated among older people who are also experiencing social and cultural isolation, poverty, and homelessness.

Limited specialist services for older AOD users

There are few programs or initiatives in Victoria specifically geared to meet the needs of older AOD users.

For instance, research in 2007 by Victorian AOD clinician Simon Ruth highlighted the lack of AOD service provision targeting older people in the Mornington Peninsula in Victoria. In 2006 there were five EFT adolescent AOD staff attending to approximately 8.3 per cent of the regional population (adolescents between the ages of 12 to 18 years). However, 25.5 per cent of the regional population were 60 years of age or over with no AOD workers targeting this demographic (Ruth 2007). This statistical disparity is of concern and demonstrates that there is a significant need to build AOD sector capacity to cater for an ageing population. For older people, the needs are not as obvious as with adolescents, as AOD challenges for this population are less visible.

Older people with AOD issues may either remain hidden in the community or present to aged care services, general practice, or hospital emergency departments with a range of other mental and physical health problems. This has a range of obvious, preventable and unnecessarily expensive cost implications for the health system.

In many instances their underlying substance use issues may go unrecognised, often masked by the expectation and perception that older people move more slowly, have poorer balance and have aches and pains (Drugs and Crime Prevention Committee 2006:1049-66). Many older people may not realise that they have an AOD dependence issue.
This highlights the need for age-appropriate screening tools to assist practitioners in other health related agencies to identify AOD issues, particularly where chronic disease and/or medication complexity is present.

However, even when AOD issues among older people are recognised, aged care services lack specialised understanding of AOD issues, or capacity to effectively respond to them, particularly in residential settings where the older person may be unwilling or unable to stop their AOD use (Rota-Bartelink 2006:1).

AOD agencies raised many of these concerns at a forum convened by VAADA in 2005 – ‘Older but not forgotten’, and again through the consultation process for VAADA’s 2010/11 state budget submission.³

Ruth suggests that older people will access treatment when it is tailored to meet their needs. Based on investigation of a number of older-adult specific services in the United States of America and Canada, Ruth’s research found that agencies may inadvertently create barriers to treatment, and identified that treatment for older adults:

- Requires longer episodes of care and needs to be slower, gentler, holistic and more flexible;
- Has a greater degree of medical complexity; and
- Is more likely to involve significant others (Ruth 2007).

VAADA believes there is a need to build on current strengths in the AOD sector to enhance its capacity to provide effective and quality AOD treatment for the expanding population of older adults. Translating this capacity into better outcomes will entail partnerships with mental health, aged care and health services.

³ See pages 6 – 7 of VAADA’s State Budget Submission 2010/2011, which proposes a model to address some of these concerns in AOD service for older adults.

VAADA’s Recommendations

Effective responses to improve support and access to drug treatment for older Victorians include:

1. Development of a service system which facilitates ease of entry into the AOD service system for older adults;
2. A pilot drug treatment project to address the gap in AOD services for older adults. The project should include outreach, project coordination, medical support coupled with funding for research and evaluation;
3. Research into patterns of AOD use among older Victorians, impact of long-term AOD use on the ageing body, and implications for appropriate screening methods, effective engagement, and treatment interventions;
4. Development of a planning strategy that focuses on generational changes in illicit drug use patterns within the context of an ageing population;
5. Assessing need and resourcing the capacity of pain management services to ensure that they can cater for a growing ageing population;
6. Development of broad-based community education campaigns to raise awareness about the increased harms associated with particular drugs on the ageing body, particularly if they are mixed with, especially alcohol, tranquillisers and painkillers;
7. Introduction of workforce development strategies, including training, to enable health and aged care providers to more appropriately respond to AOD issues amongst older people;
8. The development of stronger partnerships between primary, acute, and mental health services, aged care and AOD treatment services;
9. Development of strategies to assist isolated older persons with AOD issues to reconnect with family and participate in social networks.
References


ABS 2009, Population by Age and Sex, Regions of Australia, cat. No. 3235.0, Canberra.


Nicholas, R., Lee, N. and Roche A 2011, Responding to pharmaceutical drug misuse problems in Australia; A Matter of Balance, National Centre for Education and Training on Addiction, Flinders University, South Australia.


Disclaimer

While efforts have been made to incorporate and represent the views of our member agencies, the position and recommendations presented in this Paper are those of VAADA.