Older New Zealanders: addressing an emerging population of hazardous drinkers

Andy Towers, John McMenamin, David Newcombe, Janie Sheridan, Gillian White

A recent Lancet article forecasts that, despite a reduction since the 1990s, New Zealand's per capita alcohol consumption is expected to increase over the next decade. This contrasts with predicted declines in Australia and the UK over the same period. A critical question for New Zealanders is ‘Who is driving this trend?’ Both New Zealand and international data illustrate that those aged under 25 are not driving this trend. While those aged 25 and younger are still the age group with the greatest proportion of hazardous drinkers, there have been well-publicised reductions over the past decade in rates of such drinking in this cohort worldwide, including in New Zealand, and this trend shows no likelihood of stopping soon. Instead, New Zealand's projected increase in alcohol use over the coming decade is likely to be driven by those aged 50 and over.

Alcohol is still the drug of choice for an ageing 'Baby Boomer' cohort. While age-based alcohol legislation targeting youth is common (ie, purchase age restrictions; zero blood alcohol limits for learner drivers), few—if any—policy measures to limit alcohol availability for middle-aged and older adults are evident. Consequently, with the current transition of boomers into ‘older adulthood’ the rate of older drinkers now consuming alcohol at levels hazardous to their health has significantly increased, as has the rate of older adults with alcohol-related disorders and hospitalisations. Yet international evidence shows that addiction services (much like legislation) largely ignore older adults, indicating that our health systems may not be prepared to cope with this demographic shift in alcohol consumption.

New Zealand has seen a year-on-year doubling of addiction service users attending non-government organisations over the past decade. However, regional differences in funding of addiction services mean that we cannot determine the degree to which the rise in addiction service use over this time reflects rising use by a cohort of older hazardous drinkers. Our continued assumption that older adults are low-risk drinkers, our lack of understanding of their need for addiction services, and the potential ageism in this sector underlines why the UK Royal College of Psychiatrists identified older adults as ‘our invisible addicts’. Rising alcohol use in older adults is concerning for a number of reasons. First, aging increases the risk of alcohol-related harms as we are less capable of processing and diluting ethanol, so each drink is relatively more toxic to an older body. Second, research shows that—contrary to popular belief—there are no health benefits of moderate drinking for older adults specifically. In fact, alcohol use may best be seen as a correlate—not a predictor—of health. Third, many older drinkers also use alcohol-interactive medication for chronic health conditions, so almost 20% of older adults may be at a serious risk of medication-alcohol interaction. In short, older adults are at considerably greater harm from alcohol use than younger drinkers.

In 2015, the New Zealand Health Promotion Agency (HPA) funded a joint team from Massey University's Health and Ageing Research Team and the University of Auckland Centre for Addiction Research to explore drinking patterns, predictors and harms in older New Zealanders. This
research illustrated that New Zealanders aged 50+ consume alcohol more frequently and in higher quantity than their counterparts worldwide. Furthermore, between 35–40% drink at levels hazardous to their health due to the combination of drinking patterns and comorbidities (eg, chronic health conditions and medications that may interact with alcohol) that raise the risk of harmful outcomes.

In addition to identifying key prevalence and risk factors for older drinkers, this HPA-funded research identified two points relevant for potential intervention with this population. First, many older drinkers at-risk of alcohol-related harm would be missed by standard screens focusing on consumption only. Some of the most at-risk older drinkers in this research actually consumed at low levels, but in combination with chronic health conditions and medications that were all alcohol-interactive. Second, regardless of whether they drank or not, most older adults regularly saw their GP and those at most risk of alcohol-related harms were actually more likely to see their GP because of their comparative ill health. This highlights that primary healthcare services are an essential point of intervention for the wider health system to engage with older drinkers, screen for potential risk and identify a pathway for those in need of help.

Primary care in New Zealand has demonstrated the capacity to routinely ask about patient alcohol use and offer brief advice. A demonstration project implemented in general practices in the Whanganui region in 2010 quickly achieved high rates of coverage with practices recording between 43% and 74% of adults’ alcohol use within the first 10 months of the project. This coverage included up to 53% of Māori and 60% of New Zealand European/Pakeha attending practices. Subsequently, this approach—called the Alcohol ABC approach—has been used in a number of New Zealand general practices, most recently in the Counties Manukau District Health Board region where over half of all adults have had their alcohol use recorded in primary care in the last three years.

New Zealand’s primary care sector thus illustrates capacity for alcohol screening, but the current screening approach is not sensitive to the alcohol-related risks faced by a rising population of older drinkers. A three-module HPA-funded pilot project is now underway in Whanganui which is designed to assess a system that may work within the clinical context of long-term conditions management. First, this project integrates alcohol-related risk factors from a screening tool sensitive to older adults within an e-screening process to automatically identify those whose combined drinking, health and medication use place them at risk of harm. Second, this project integrates training in motivational interviewing based on Matua Raki’s Takitaki Mai guide to improve practitioner confidence in initiating and managing alcohol-related conversations with Māori and non-Māori populations. Third, a case study of the development, initiation and outcomes of this pilot project will—if successful—offer a blueprint for other district health boards to support the roll-out of this enhanced alcohol screening and management process for older drinkers.

The nature of alcohol use in New Zealand is changing. Youth, for a long time the focus of our attention, are reducing their consumption. Conversely, older adults, long assumed a population of low-level drinkers, now show a rise both in hazardous drinking and alcohol-related risk. Our health system, particularly primary care, needs to adapt to this change. This requires not only asking older adults about alcohol but understanding the degree to which even low-level consumption patterns raise risk of harm for those with comorbidities. This HPA-funded pilot is a first step in the process. Changing our attitude towards, and understanding of, alcohol use in later life is a culture change that will take a lot longer.
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Author information:
Andy Towers, School of Health Sciences, Massey University, Palmerston North;
John McMenamin, Health Solutions Trust, Whanganui;
David Newcombe, School of Population Health, University of Auckland, Auckland;
Janie Sheridan, School of Pharmacy, University of Auckland, Auckland;
Gillian White, Health Solutions Trust, Whanganui.

Corresponding author:
Andy Towers, School of Health Sciences, Massey University, Private Bag 11222,
Palmerston North.
a.j.towers@massey.ac.nz

URL:

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