Submission to the Office for Seniors
on the
Draft Strategy: Better Later Life – He Oranga Kaumātua 2019 to 2034

31 May 2019

Alcohol Healthwatch is an independent Charitable Trust working to reduce alcohol-related harm. We are contracted by the Ministry of Health to provide a range of regional and national health promotion services. These include: providing evidence-based information and advice on policy and planning matters; co-ordinating networks and projects to address alcohol-related harms, such as Fetal Alcohol Spectrum Disorder; and co-ordinating or otherwise supporting community action projects.

Thank you for the opportunity to provide feedback on the draft strategy, Better Later Life – He Oranga Kaumātua 2019 to 2034.

We acknowledge that this submission will be published, and we wish to speak to this submission if the opportunity arises.

If you have any questions on the comments we have included in our submission, please contact:

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Executive Summary

1. Alcohol Healthwatch welcomes the Draft Strategy that takes a whole of society approach to improving the well-being of older adults in New Zealand.

2. Alcohol Healthwatch strongly recommends that the Draft Strategy restate the disparities in life expectancy between Māori and non-Māori that are documented in the Healthy Ageing Strategy 2016. These inequities must be at the forefront of all sectors in society, not just the health sector.

3. Alcohol Healthwatch recommends that policy and intervention development going forward occurs in partnership with older adults, their families and caregivers.

4. Alcohol Healthwatch warns that current alcohol use patterns among older people are likely to compromise the ability of the Strategy to achieve its vision. For example, between 20-30% of men aged 45-74 years are classified as hazardous drinkers. International research shows that older adults in New Zealand have higher levels of drinking when compared to other similar countries.

5. Harms from alcohol are often greater among older adults due to a higher physiological sensitivity to alcohol, presence of co-morbid health conditions, and interference of alcohol with prescription medications. This places older adults at a higher risk of alcohol-related mental health issues and a greater likelihood of alcohol-related injuries and death.

6. Alcohol Healthwatch strongly recommends that evidence-based alcohol-specific actions are included in the initial priorities of the Strategy and subsequent Action Plan to be developed. Alcohol must not be the ‘silent epidemic’ in older adults. To reduce the burden of alcohol harm to older adults requires:
   a. Implementation of effective and cost-effective alcohol policies, that include: increasing the price of alcohol, reducing its availability, and restricting alcohol sponsorship, advertising, and promotion.
   b. Implementation of a nation-wide alcohol screening, brief intervention, and referral to treatment programme. Specific screening and treatment programmes should be developed for older New Zealanders.
   c. Development of specific lower-risk drinking guidelines and training for health professionals, as well as social and community service providers, in relation to the harms from drinking in older age.
   d. Development of a National Alcohol Strategy and Action Plan, that includes older adults as a priority group.
   e. Enhance cross-sector, whole-of-systems approach to alcohol harm. There is a need to make better use of common points of contact across the health and social sectors to identify and support older people with mental health and alcohol and other drug problems.
Feedback on the vision of the Draft Strategy

7. Alcohol Healthwatch agrees with the vision of the Draft Strategy “Older New Zealanders lead valued, connected and fulfilling lives”.

8. Whilst we recognise that the draft Strategy takes a wide view of well-being and is intended to be a roadmap for all of society to achieve better outcomes for all New Zealanders, we wish to strongly signal that current alcohol use patterns among older people are likely to compromise the ability of the Strategy to achieve its vision.

9. We strongly recommend that evidence-based alcohol-specific actions are included in the initial priorities of the Strategy and subsequent Action Plan to be developed. The issue of, and trends in, alcohol use among older adults in New Zealand warrants significant concern and attention.

10. We recognise that many of the issues that are documented in this submission more closely align to the Healthy Ageing Strategy 2016. However, as the two Strategies complement each other we have opted to present this information in the current consultation process.

11. We are very concerned that the key drivers of alcohol use among older people (low prices and high availability) are NOT addressed in the Healthy Ageing Strategy 2016. This significantly compromises the ability of the Healthy Ageing Strategy to achieve its vision, particularly in relation to its actions on alcohol.

12. Furthermore, it is essential that the Draft Strategy restate the disparities in life expectancy between Māori and non-Māori. Although these are included in the Healthy Ageing Strategy 2016, all sectors (e.g. housing, education, employment) of society have a responsibility to reduce these inequities. Furthermore, examination of the level of inequity in every priority area outlined in the Draft Strategy must be reported and regularly monitored.

The differential effects of alcohol use on older adults

13. There is considered no safe level of alcohol use among older adults. (1,2)

14. Older adults are more susceptible to the harmful effects of alcohol at any level of consumption. The same amount of alcohol produces a higher blood alcohol concentration in older than younger adults due to changes in body composition, leading to a longer time for the acute effects of alcohol to diminish. The ability to absorb, metabolise, and excrete alcohol remains largely unchanged with increasing age. (2)

15. Thinking skills and memory, co-ordination and mobility may also be more affected by alcohol among older adults. Alcohol also affects emotions and mood.(3)

16. Conditions such as co-morbidities, medication interaction, and other risky behaviors including drinking driving, further contribute to more harmful effects of alcohol on older adults.(4)

17. Although there has been debate over the potential “health benefits” from low-risk drinking (particularly for older drinkers), recent research suggests that the findings of benefit were more likely the result of methodological differences in studies (5) and under-adjustment for confounding factors (e.g. personal characteristics) that relate to different drinking patterns within the population.(1,2) It is advised that there is no overall positive health benefit for older adults from drinking.(2)

18. New Zealand research supports the findings that there are differences in the characteristics of older drinkers who have moderate versus high-risk intakes. These differences must be well-controlled in studies that examine health outcomes from drinking. The former were more likely
to be wealthier (6), whilst the latter were more likely to have lower levels of economic standards than other drinking profiles.

Drinking patterns among older adults in New Zealand: New Zealand Health Survey

19. Alcohol use among older age remains common, although decreases with advancing age. The 2017/18 New Zealand Health Survey (7) found that the prevalence of drinking in the past year among older men and women was:

- 45-54 years: 86.2% among men, 79.8% among women
- 55-64 years: 83.9% among men, 77.3% among women
- 65-74 years: 82.7% among men, 72.8% among women
- 75+ years: 77.3% among men, 57.4% among women

20. As shown in Table 1, one in every five (19.8%) New Zealand adults aged 15 years and above were classified as hazardous drinkers (around 775,000 adults) in the survey.

Note: The World Health Organisation defines hazardous drinking as “a pattern of alcohol consumption that increases the risk of harmful consequences for the user or others. Hazardous drinking patterns are of public health significance despite the absence of any current disorder in the individual user.” (8)

Table 1 Prevalence (%) of hazardous drinking, 2017/18 New Zealand Health Survey (7)

<table>
<thead>
<tr>
<th>GROUP</th>
<th>TOTAL (%)</th>
<th>MALE (%)</th>
<th>FEMALE (%)</th>
<th>EST. NUMBER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>19.8</td>
<td>27.3</td>
<td>12.7</td>
<td>775,000</td>
</tr>
<tr>
<td>Age group (years)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15-17</td>
<td>7.2</td>
<td>7.8</td>
<td>6.7</td>
<td>14,000</td>
</tr>
<tr>
<td>18-24</td>
<td>31.7</td>
<td>38.1</td>
<td>24.8</td>
<td>151,000</td>
</tr>
<tr>
<td>25-34</td>
<td>25.3</td>
<td>34.6</td>
<td>15.9</td>
<td>177,000</td>
</tr>
<tr>
<td>35-44</td>
<td>22.0</td>
<td>29.1</td>
<td>15.4</td>
<td>129,000</td>
</tr>
<tr>
<td>45-54</td>
<td>22.2</td>
<td>29.9</td>
<td>15.0</td>
<td>141,000</td>
</tr>
<tr>
<td>55-64</td>
<td>16.1</td>
<td>25.2</td>
<td>7.7</td>
<td>93,000</td>
</tr>
<tr>
<td>65-74</td>
<td>12.5</td>
<td>19.5</td>
<td>5.9</td>
<td>53,000</td>
</tr>
<tr>
<td>75+</td>
<td>5.1</td>
<td>9.5</td>
<td>1.6</td>
<td>16,000</td>
</tr>
</tbody>
</table>

21. As shown above, New Zealanders aged 45 years and above comprised almost 40% (303,000) of all hazardous drinkers in 2017/18.

22. Whilst 18 to 24 year olds maintain the highest (31.7%) prevalence of hazardous drinking in the country, hazardous drinking patterns remain prevalent throughout older age groups in New Zealand, particularly among men.

23. In 2017/18, the prevalence of hazardous drinking among men was (Table 1):

- 29.9% among those aged 45 -54 years;
- 25.2% among those aged 55-64 years;
- 19.5% among those aged 65-74 years, and
- 9.5% for those aged 75 years and above.
24. Of particular concern, there have been significant increases in hazardous drinking over time among older age groups in New Zealand (Figure 1) (7)

25. Following declines in hazardous drinking between 2006/07 and 2011/12, the prevalence of hazardous drinking increased from 2011/12 to 2015/16. These increases were substantial:
   - increased by more than 50% among those aged 45-54 years (11.7% to 18.5%);
   - increased by more than 70% among those aged 55-64 years (8.4% to 14.4%); and
   - more than doubled for those aged 65-74 year (from 5.5% to 10%).

26. Therefore, all of the positive reductions in drinking that had been achieved between 2006/07 and 2011/12 were lost by 2015/16. Of particular concern, the level of increase was so great that some age groups (35-44yrs, 45-54yrs, 65-74yrs) had significantly higher levels of hazardous drinking in 2015/2016 than in 2006/07.

27. The New Zealand Health Survey methodology changed in 2015/16 so more recent comparisons are not possible. However, there have been no significant changes in the prevalence of hazardous drinking in the past three years of comparable surveys (i.e. 2015/16, 2016/17, and 2017/18). (Figure 1) (7)

28. Figure 1 shows that the age cohorts that are about to reach older age have been on a recent trajectory of increasing alcohol consumption. (7) Action is urgently required now to prevent this age group continuing to drink at high levels in older age.

![Figure 1](image_url)

Figure 1. Unadjusted prevalence of hazardous drinking 2006/07 to 2017/18, among adults >34 years. Break in the graph represents changes in the measurement of an alcoholic drink.

29. Should these trends continue, older people will represent a much greater proportion of hazardous drinkers in New Zealand. This is due to the population of older adults being predicted to double by the year 2036 (based on the projection from 2013). At this point, approximately 24% of the population will be aged 65 years and over. (9) High levels of alcohol use in older populations will have significant implications on our strained healthcare system and will compromise well-being in older adults. (10)
Drinking patterns among older adults in New Zealand: other survey measures

30. The annual New Zealand Health Surveys utilise the Alcohol Use Disorders Identification Test (AUDIT) to assess the prevalence of hazardous drinking in New Zealand (7). However, this test is not age-specific. Other measures have been developed to quantify alcohol use in older people.

31. One New Zealand study (4) assessed the prevalence of hazardous drinking using the shortened AUDIT (AUDIT-C) test as well as the CARET (Comorbidity Alcohol Risk Evaluation Tool), which was specifically developed for assessing hazardous drinking in older adults.

32. The CARET tool takes into account other factors that relate to alcohol use and harm among older adults, not just an older person’s drinking frequency and quantity. These factors include chronic health problems, alcohol-medicine interactions, and alcohol-related risk behaviors which may give rise to older people experiencing more harm from their drinking (4).

33. Depending on the screening tool used, between 35% (the CARET) and 40% (the AUDIT-C) of older New Zealanders were classified as hazardous drinkers. (4) Among older adult men, almost 50% were classified as hazardous drinkers using either the AUDIT-C or the CARET.

34. Another NZ study (11) identified the factors associated with older New Zealanders (aged 50 and above) consuming alcohol with high frequency. These were:
   - being male;
   - at younger stage of older adulthood (i.e., around 60-70 years of age);
   - having moderate to high levels of education;
   - having a high economic living standard, and
   - smoking.

35. Hazardous drinking was not found to be associated with ethnicity in older people, as Māori and non-Māori had a similar prevalence of hazardous drinking. (11)

Factors influencing drinking in older people

36. Factors that may be influential in older adults increasing their drinking include (3):
   - greater involvement in alcohol-based social activity;
   - having more leisure time;
   - fewer family responsibilities;
   - having more money;
   - possessing more relaxed attitudes to alcohol;
   - responding to bereavement or loneliness;
   - relieving or masking chronic pain; and
   - countering insomnia, distress or anxiety.

37. Factors that may be influential in older adults cutting down their drinking include:
   - less involvement in social activities;
   - more involvement in hobbies or interests that don’t involve drinking;
   - fewer opportunities to drink;
   - pressure from others to cut down;
   - biological intolerance to alcohol;
   - reduced disposable income;
   - development of health problems including problems made worse by drinking, and
   - starting on medicines not compatible with alcohol.
Drinking patterns among older adults in New Zealand: categories of drinkers

38. A further New Zealand study sought to categorise older New Zealand drinking patterns. (11)

39. Five drinking profiles were identified. (Figure 2)

<table>
<thead>
<tr>
<th>Profiles of Older Drinkers</th>
<th>Characteristics</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1</strong></td>
<td>Low Frequency of Drinking Low Quantity per Occasion (34.8%; n = 915)</td>
<td>A group with a low frequency of drinking, low levels of consumption on days when they do drink, and who experience a small but gradual decrease over time in both drinking frequency and quantity.</td>
</tr>
<tr>
<td><strong>2</strong></td>
<td>High Frequency of Drinking Low Quantity per Occasion (30.1%; n = 781)</td>
<td>A group of very frequent drinkers who consume low amounts on each drinking occasion, and show no change (increase or decrease) in the frequency or quantity of alcohol use over time.</td>
</tr>
<tr>
<td><strong>3</strong></td>
<td>Moderate Frequency of Drinking High Quantity per Occasion (4.7%; n = 124)</td>
<td>A very small group of drinkers who drink with moderate frequency and they consume a lot on occasions when they do drink (infrequent heavy drinkers). However, both the frequency of drinking and the quantity consumed per occasion reduces across time.</td>
</tr>
<tr>
<td><strong>4</strong></td>
<td>Moderate Frequency of Drinking Low Quantity per Occasion (22.6%; n = 594)</td>
<td>A group that tends to drink with moderate frequency, consumes low quantity per drinking occasion, and both drinking frequency and quantity gradually decrease across time.</td>
</tr>
<tr>
<td><strong>5</strong></td>
<td>High Frequency of Drinking High Quantity per Occasion (7.0%; n = 207)</td>
<td>A small group of older drinkers who drink frequently and consume a high quantity of alcohol on each drinking occasion (frequent heavy drinkers). Also, while the average quantity consumed decreases slightly over time, the frequency of drinking does not.</td>
</tr>
</tbody>
</table>

*Figure 2. Overview of the five profiles of older New Zealand drinkers (11)*

Note: Profile numbers indicate the order in which drinking groups emerged from the analysis — they are not suggesting increasing risk.

40. Together, approximately 13% of all older drinkers in the study had very high-risk drinking profiles — Profile 3 (4.7%) (moderate frequency – high quantity per occasion) and Profile 5 (7.9%) (high frequency – high quantity per occasion).

41. Older drinkers in Profile 5 had slightly higher economic living standards than those in Profile 1. Both high-risk groups were more likely to be smokers than older drinkers who consumed fewer drinks per drinking occasions (11).

42. Heavy drinkers in Profile 3 drinkers had the poorest physical and mental health. Compared to other drinker groups, they were more likely to have three or more chronic health conditions, lower education levels, and significantly lower economic living standards. (11) They were the drinking profile that consumed alcohol in large quantity on each occasion.

43. In a recent international study of older people’s drinking, New Zealand drinkers were found to have some of the highest levels of drinking across the countries studied. (12) The proportion of frequent heavy drinkers was higher in New Zealand compared with most countries, including England and the United States.
Alcohol-related harm among older adult drinkers in New Zealand

44. Little is known about alcohol harm among older adults, as well as the role of alcohol in older people’s lives. The issue of older adult drinking is often described as a “silent epidemic” (2), given that drinking problems in older adults have often been ignored both by health professionals and health researchers.

45. Alcohol use is a significant factor contributing to the burden of disease and injury in New Zealand. Health harms are often aggravated by the higher physiological sensitivity among older adults to alcohol, co-morbid health conditions, interference of alcohol on medications, a higher risk of alcohol-related mental health issues, and a greater likelihood of alcohol-related injuries and death.(2,3)

46. Hazardous drinking is a contributing factor to a range of chronic health conditions in older adults, although the relationships between alcohol and various conditions may differ and appear to be complex.(3) The risks of developing chronic conditions may relate to the cumulative effects of alcohol use across the lifespan, in combination with the effects of specific drinking occasions (e.g. heavy drinking episode). Health harms include liver disease, pancreatitis, cancer, stroke, and high blood pressure.

47. Alcoholic beverages are classified as a Group 1 carcinogen and are causally related to seven types of cancer (oropharyngeal, laryngeal, oesophageal, colon, liver, rectum, female breast).(13)

48. A large cohort study has shown that even low levels of alcohol consumption, 1 or 2 standard drinks per day, are associated with an increased risk of stroke. Stroke risk increases with increasing consumption. (14)

49. Alcohol consumption over time is also associated with detrimental effects on brain structure. It has been found that alcohol use disorders are a major risk factor for the onset of all types of dementia, especially early-onset dementia. (15)

50. The high prevalence of drinking among New Zealand men contributes to alcohol use being the 5th strongest risk factor for death among men aged 50-69 years (Figure 3).(16)

![Figure 3. Behavioural risk factors for death among New Zealand men aged 50-69 years, 2016.](image-url)
51. Table 2 shows the top five causes of alcohol-related deaths in 2007 among New Zealanders aged 45 years and above. In the total population under the age of 80 years, there were 802 deaths that were attributable to alcohol.(17)

52. As shown in Table 2, cancers and other chronic conditions were the leading causes of alcohol-attributable deaths among older adults in New Zealand in 2007.

Table 2. Top five causes of alcohol attributable (AA) deaths, by age and sex (2007) (17)

<table>
<thead>
<tr>
<th></th>
<th>Males</th>
<th>Females</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>% of all AA deaths</td>
<td>% of all deaths</td>
</tr>
<tr>
<td>45-59 years (n=122)</td>
<td>7.4%</td>
<td>45-59 years (n=70)</td>
</tr>
<tr>
<td>Alcoholic liver cirrhosis</td>
<td>24.6%</td>
<td>Female breast cancer</td>
</tr>
<tr>
<td>Other unintentional injuries</td>
<td>9.9%</td>
<td>Alcoholic liver cirrhosis</td>
</tr>
<tr>
<td>Self-inflicted injuries</td>
<td>9.3%</td>
<td>Haemorrhagic stroke</td>
</tr>
<tr>
<td>Mouth/oropharynx cancers</td>
<td>6.1%</td>
<td>Alcohol use disorders</td>
</tr>
<tr>
<td>Liver cancer</td>
<td>6.0%</td>
<td>Self-inflicted injuries</td>
</tr>
<tr>
<td>60-69 years (n=98)</td>
<td>4.6%</td>
<td>60-69 years (n=98)</td>
</tr>
<tr>
<td>Alcoholic liver cirrhosis</td>
<td>22.5%</td>
<td>Female breast cancer</td>
</tr>
<tr>
<td>Mouth/oropharynx cancers</td>
<td>12.6%</td>
<td>Alcoholic liver cirrhosis</td>
</tr>
<tr>
<td>Oesophagus cancer</td>
<td>11.8%</td>
<td>Colon cancer</td>
</tr>
<tr>
<td>Rectum cancer</td>
<td>7.1%</td>
<td>Haemorrhagic stroke</td>
</tr>
<tr>
<td>Haemorrhagic stroke</td>
<td>6.7%</td>
<td>Rectum cancer</td>
</tr>
<tr>
<td>70-79 years (n=102)</td>
<td>2.7%</td>
<td>70-79 years (n=68)</td>
</tr>
<tr>
<td>Haemorrhagic stroke</td>
<td>15.4%</td>
<td>Female breast cancer</td>
</tr>
<tr>
<td>Oesophagus cancer</td>
<td>14.4%</td>
<td>Haemorrhagic stroke</td>
</tr>
<tr>
<td>Alcoholic liver cirrhosis</td>
<td>6.9%</td>
<td>Colon cancer</td>
</tr>
<tr>
<td>Colon cancer</td>
<td>7.6%</td>
<td>Ischaemic heart disease</td>
</tr>
<tr>
<td>Rectum cancer</td>
<td>7.2%</td>
<td>Rectum cancer</td>
</tr>
</tbody>
</table>

53. Among New Zealand women drinkers, breast cancer was the leading cause of alcohol-attributable death, and comprised 61% of all alcohol-attributable cancer deaths among women.

54. Low-level alcohol consumption contributed to these deaths from breast cancer.(18,19) More than one-third of alcohol-attributable breast cancer deaths were due to an average consumption of less than two standard drinks per day.(18) This finding supports other research showing that the risk of cancers begin at low levels of consumption and that there is considered no safe level of alcohol consumption for cancer prevention.(20)
Feedback on the five guiding principles of the Draft Strategy

55. Alcohol Healthwatch agrees with the five guiding principles. Again, we wish to emphasise that the current levels of alcohol use among older people (as well as high levels of hazardous drinking among New Zealanders about to reach older age) will compromise the guiding principles of the Strategy.

Feeling valued

56. Alcohol Healthwatch recognises the importance of feeling valued in one’s life, home, work, social, and national environment. Feeling valued gives a sense of belonging and purpose.

57. However, age discrimination can reduce an individual’s sense of value. Age discrimination may arise due to pervasive misconceptions, attitudes, and assumptions based on stereotypes.(21) These factors may give rise to older adults being perceived by others as incapable of change. As a UK Report noted, people are often not aware of their prejudices and age discrimination is rarely a result of malign intentions or motives.(21)

58. Age discrimination can seriously impact an individual’s access and delivery of core services.

59. For example, age may render alcohol use a ‘hidden problem’ among older adults, resulting in policymakers, service and treatment providers, and academics ignoring the harm from alcohol in this group. For example, one UK report (21) found that older adults were less likely to be offered alcohol treatment due to their age. Treatment service providers were found to prioritise younger clients over older adults. However, delivery of brief interventions may be higher among older age groups than young adults.(22)

60. Overall, older adults that consume alcohol hazardless or harmfully (including some with alcohol use disorder) have been found to be hidden in the community (3), not seeking help nor being adequately identified or engaged by health and social services. Several factors were identified to contribute to this scenario:

- social attitudes condoning problematic alcohol use by older adults or denying it exists,
- concerns by older adults being stigmatised as problem drinkers or alcoholics, and
- health professionals’ sensitivities and difficulties in raising alcohol issues with older clients.

Keeping older adults safe, free from abuse and neglect

61. Alcohol use in society, especially heavy drinking, is a significant contributor to safety in our communities.

62. Alcohol use is major driver of crime and violence in New Zealand.(23) Whilst there is no data on alcohol-related violence against older adults, approximately one-third of all family harm investigations involve alcohol and/or drug use. (24) Māori women, in particular, are more likely to experience violence committed by someone under the influence of alcohol.(25)

63. High numbers of alcohol outlets and late trading hours can lead to increased violence, drink driving, and heavy drinking in a community.(26,27) Drinking in public places also contributes to significant harm and disorder.(26)

64. When residents perceive their community to be unsafe, they are less likely to venture into their neighbourhood to form healthy relationships. New Zealand research shows that perceptions of safety are significantly associated with a sense of community.(28)

65. It is concerning that more New Zealanders report alcohol and drug issues as the biggest problems in their neighbourhood, compared to other crime and safety issues (29). In a study of
residents across seven cities in New Zealand, 60% of respondents perceived alcohol or drugs problems, or anti-social behaviour associated with alcohol use, to be a problem in their city or local area.

**Taking a whole-of-life and whānau-centred approach to ageing**

66. Alcohol Healthwatch strongly supports a whole-of-life and whānau-centred approach. Of all New Zealanders that develop alcohol use disorders (AUD), approximately 50% will develop AUD by the age of 20 years and 75% by age 25. (30) Turning down the tap of alcohol use among young people is imperative if we want to reduce problems in later years.

67. A whānau-centred approach is essential to support healthy ageing and also upholds New Zealand’s obligations to the Treaty of Waitangi.

68. However, a whānau-centred approach must not translate to devolution of responsibility of support to whānau. Supportive social and economic structures in society must be in place: communities cannot, and must not, do this on their own.

**Taking collective responsibility to plan and act for later life**

69. We agree that collective action is required from all sectors of society to improve the well-being of older adults.

70. As recommended by the Mental Health and Addiction Inquiry Panel (31), New Zealand requires strong leadership and cross-sectoral coordination from central government “given the significant role that alcohol and other drugs play in people’s wellbeing across New Zealand.”

71. Together, we have all a responsibility towards improving the health and well-being of others.
Feedback on five key areas for action

72. Alcohol Healthwatch agrees with the five key action areas. Suggestions are made for each in the following paragraphs.

Preparing for financial and economic security (including through employment)

73. In older adults aged 60 years and over, hazardous drinking has been linked to early work exit before the retirement age. (32)

74. The New Zealand Alcohol Use 2012/13 survey found that 4.3% of New Zealanders aged 45-54 years and approximately 3% of 55-74 year olds experienced financial harms from their own drinking in the past year. (33) As such, alcohol use does impact directly on the financial security of older people. Financial harms are also reported as a result of the drinking of others.

75. At the societal level, the level of alcohol use in a population is negatively correlated with economic growth; the higher the consumption, the lower the growth. (34) As such, addressing alcohol use in the society can assist Governments to ensure there is adequate revenue to provide financial assistance to older New Zealanders.

76. Each year, alcohol harm is estimated to cost around $7.85 billion – this includes costs to the individual, family, the Government (e.g. healthcare system), and the society (including lost productivity). (35) Cost savings from reduced harm could be diverted to services targeted to older adults.

Improving access to health and social services

77. If reductions in hazardous drinking do not occur in the population, there will be further strain placed on our healthcare system, especially in the presence of an ageing population.

78. We would welcome accessible screening, brief intervention and treatment programmes that are effective for older adults, taking into account their particular vulnerabilities (harm from lower levels of consumption) and needs in relation to minimising harm (e.g. health conditions, medication interaction, and alcohol-related risk behaviours).

79. We would also welcome the consideration of utilising an older adult-specific alcohol use questionnaire in national surveys of alcohol use.

80. For instance, the Comorbidity Alcohol Risk Evaluation Tool (CARET) may have used in population surveys of older adults. The CARET assesses hazardous drinking based on a range of factors that contribute to harm. (4) Figure 4 summarises the components of the CARET assessment tool.
This tool is a shortened-version of the Alcohol-Related Problem Survey (APRS), developed by a panel of international experts in gerontology, geriatrics, and alcohol use in the United States (4). It is used to assess alcohol-related risk and levels of consumption in the presence of factors that may impose more harm (e.g. alcohol-medication interaction, existing health conditions that associate with alcohol use, co-morbidities, risk behaviours, etc). The APRS may be more useful in identifying drinkers that may be at risk of harm from drinking at non-hazardous levels.

a) Lower-risk drinking guidelines for older adults

Current low-risk drinking guidelines in New Zealand are not age-specific for those above the legal purchase age (i.e. 18 years). For young people under 18 years, the advice is that not drinking is the safest option and to delay drinking for as long as possible. (36)

For everyone else (other than pregnant women), guidelines are sex-specific, with lower daily and weekly limits for women than men.

It is recommended that lower-risk drinking guidelines accommodate the needs of older adults (3). Guidelines should take account of the physiological capacity of older adults to process alcohol and their greater susceptibility to alcohol-related harm at relatively low levels of consumption. For example, in Italy, older adults are recommended not to exceed one alcoholic beverage per day. (3)

Alongside the development of guidelines is the need to increase awareness of the harms from drinking among older adults and others (e.g. health practitioners) (3). Screening programmes in primary care are recommended. (37)

Alcohol Healthwatch recommends that a nation-wide alcohol screening, brief intervention, and referral to the treatment programme be implemented within healthcare (e.g. primary care, hospitals (including Geriatrics wards)) and community settings. Screening for at-risk drinkers and providing them with brief intervention is a cost-effective measure to reduce hazardous and harmful drinking. (38)

A similar, comprehensive approach that has been applied to smoking cessation in New Zealand could be applied to alcohol screening and treatment.
Providing housing choices and options so people can age in the community

88. Alcohol Healthwatch has no specific recommendations for this action area. However, we acknowledge the importance of having appropriate shelter for older adults, as it provides a safety net, is a human right and pre-requisite for health.

89. It is plausible that housing insecurity influences alcohol use in the population. It is well-known that alcohol, drug and gambling addictions are associated with homelessness in New Zealand.(39)

Enhancing opportunities for social connection and participation

90. Alcohol Healthwatch acknowledges the importance of feeling connected to the significant people and places in our lives. (40) Supportive social relationships provide people with a sense of belonging, connection, value, care, and respect, which promotes well-being (41,42)

91. In relation to social connectedness, many older adults drink to be social, enhance social situations or gain confidence. (3) However, older adults may also increase their drinking when they have greater involvement in alcohol-based social activity (e.g. sport clubs). Therefore, the role of alcohol in maintaining social cohesion in older adults must be carefully balanced against the harm from alcohol that may occur.

92. Older adults also drink to cope with personal situations, such as when they feel under pressure, want to forget problems, or feel lonely. (3) Alcohol misuse has been found to be strongly associated with psychosocial factors such as social isolation, financial problems, retirement, life events, pain, and insomnia.(43)

93. One New Zealand study examined the pattern or trajectory of alcohol use over the lifespan (44), finding that drinking patterns were mostly stable. Transitions into or out of hazardous drinking were not common (less than 10% in each decade) and were usually triggered by single life-events such as unemployment and relationship breakdown. However, hazardous drinking did not increase the probability of future divorce or separation. (44)

94. Alcohol Healthwatch recommends that more support should be provided for older adults who are encountering significant events in their lives. Support and training also needs to be provided to social and community service providers, in order for them to recognise events which may trigger alcohol use so that they can intervene to minimise harm.

95. Furthermore, the impact of hazardous alcohol use on dementia (15) should also be considered as a contributor to mental health issues and loneliness in later life.

96. It is also clear that the levels of alcohol use in a community impact on attitudes and norms in relation to co-ordination and collaboration between people. Social connections and social capital can be compromised in a neighbourhood that has high levels of drinking.(45,46)

Providing accessible built environments so people can participate in their community

97. Alcohol Healthwatch supports providing more age-friendly environments for older New Zealanders to connect and participate in their community. Older adults who are more involved in hobbies or interests that do not involve drinking, are more likely to cut down their drinking. On the contrary, those who have more leisure time tend to increase their drinking. (3)

98. It is also imperative that age-friendly environments do not isolate older people from younger adults. It is essential for the building of social cohesion in society that different generations come into regular contact with one another, to break down stereotypes and increase acceptance.
Feedback on priority action areas

99. Alcohol Healthwatch agrees with the initial priorities chosen.

100. In relation to the key action area – **improving access to health and social services**, the Healthy Ageing Strategy 2016 (47) has recommended the following actions areas:

- Encourage services and providers to promote the reduction of alcohol-related harm, and
- Enhance cross-sector, whole-of-systems ways of working. There is a need to make better use of common points of contact across the health and social sectors to identify and support older people with mental health and alcohol and other drug problems earlier.

101. However, fundamental changes are required to New Zealand’s drinking culture in order to curb harm and reduce inequities. Health service interventions are unlikely to be effective in reducing harm when the wider environment does not support change. New Zealand has concerning trends in relation to the increasing affordability of alcohol (48), high levels of availability and ubiquitous exposure to alcohol marketing.(26) Urgent action is required to implement evidence-based policies (26,27,38), including:

- Increasing the price of alcohol
- Reducing availability
- Restricting alcohol advertising and sponsorship

Conclusion

102. To conclude, Alcohol Healthwatch recommends the following be considered in a whole-of-society approach to improving well-being among older adults:

- Understand the needs of older adults, their families, and caregivers by consulting and engaging them in policy and intervention development;
- Ensure that the issue of alcohol use in older New Zealanders is a key agenda item in the Action Plan for 2021 to 2024;
- Implement effective and cost-effective policy measures to reduce alcohol-related harm in New Zealand. This includes reducing the availability of alcohol, increasing the price of alcohol, and removing alcohol sponsorship, advertising, and promotion;
- Implement a nation-wide alcohol screening, brief intervention, and referral to treatment programme. This includes:
  - Specific screening and treatment programmes developed for older New Zealanders.
  - Developing training and raise awareness among health practitioners are others of the risks of alcohol harm among older New Zealanders;
- Develop lower-risk drinking guidelines that are specific for older New Zealanders;
- Develop a National Alcohol Strategy and Action Plan, that includes older adults as a priority group; and
• Enhance cross-sector, whole-of-systems ways of working. There is a need to make better use of common points of contact across the health and social sectors to identify and support older people with mental health and alcohol and other drug problems earlier.

Characteristics of submitter:
• Auckland-based
• Organisation submission = Alcohol Healthwatch Trust, not from an individual
• Email esther@ahw.org.nz for updates about the Strategy

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