

Alcohol and Older People



Research and Scoping Exercise into the Impact of Alcohol on Older People across Cardiff and the Vale of Glamorgan

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Definitions

Older person/adult: For the purpose of this report, an 'older person' is someone aged 60 years and over.

Problem drinking: Use of alcohol at a level which can cause psychological, physical or social harm (Wadd et al., 2011)

Recommended daily units: There is debate about what constitutes harmful/hazardous drinking in older people. The Royal College of Psychiatrists argue that current safe limits are based on research on younger people, arguing that the upper safe limit for older people is 1.5 units a day or 11 a week. They also recommend that in older people binge, drinking should be defined as >4.5 units in a single session for men and >3 units for women (Royal College of Physicians, 2011).

Early-onset drinker: An individual who started drinking problematically before the age of 40 (Widner & Zeichner, 1991; Wadd et al., 2011).

Late-onset drinker: An individual who started drinking problematically after the age of 40 (Widner & Zeichner, 1991; Resnick & Junlapeeya; Wadd et al., 2011).

Baby Boomers: A person born in the years following the Second World War, when there was a temporary marked increase in the birth rate (Oxford Dictionary, 2014).

At the time of data collection, current estimates of older adults (60 years +), living in Cardiff and the Vale of Glamorgan, were 95,493.

Of these, 63,211 lived in Cardiff and 32,282 lived in the Vale.

42,770 (of the total amount) were male and 52,723 were female.

(Stats Wales, 2014).

Executive summary

Following recommendations made by Alcohol Concern, the Cardiff and Vale Area Planning Board commissioned a report exploring the impact of alcohol on older people across Cardiff and the Vale of Glamorgan. The projects aims were twofold: on the one side exploring data relevant to older adults (current estimates of harmful and problem drinking, numbers accessing/not accessing services and barriers to engagement), and on the other side exploring data relevant to service providers and practitioners (current levels of harm/health problems related to alcohol, what service providers feel needs to be done and how best to ensure older people and their families get accurate information about alcohol use). In terms of collecting data, a mixed method approach - quantitative (questionnaires) and qualitative (interviews/focus groups) - was employed for both older adults and service providers/practitioners.

Results from the older adults' questionnaire revealed that a significant number of older adults, living in Cardiff and the Vale, demonstrate potentially unsafe levels of alcohol use (approximately 16,902 when generalised) and need advice based around safe limits. The results also demonstrated that a significant proportion of those who should potentially be engaging with services were not doing so. Barriers to engagement were both within the individual (shame, embarrassment, denial and/or a lack of awareness) and external to the individual (services not being age appropriate). Interviews with older adults highlighted how drinking is very much ingrained as the cultural norm for older adults based on the generation in which they were raised.

Results from service providers/practitioners revealed high levels of alcohol related physical injuries, detrimental health consequences, mental health correlations and day-to-day effects including self neglect and poor hygiene. Recommendations from both the quantitative responses and focus groups with service providers/practitioners revealed a need for:

- Age-appropriate services for older problem drinkers (or at least an arm within current services);
- Better communication and pathways between current services;
- More screening, interventions and specialist aftercare;
- Training and professional development for all staff working with older adults;
- Unambiguous public health messages which challenge ageist attitudes and myths that surround alcohol misuse.

The ageing of the 'baby boomers', coupled with a rise in life expectancy, suggests that this is not just a problem that older adults, services and practitioners are faced with now, but will be an increasing problem for the future. These results and recommendations may be used as a baseline to inform not only future research but future policy context and potential interventions/services designed – hopefully – with older adults in mind.

Introduction and review

Introduction:

Alcohol misuse amongst adults 60 years and over is one of the fastest growing health problems facing the country. However, even as the number of older adults suffering from this disorder climbs, the situation remains underestimated, under-diagnosed, and undertreated. Until relatively recently, alcohol misuse in older adults was not discussed in either the substance misuse or gerontology literature, thus demonstrating the 'newness' of such research concern. Some researchers summarise the issue of alcohol misuse in older adults as a "hidden epidemic" and call for positive action to address the issue so that more people in Wales can enjoy a healthy retirement (e.g. Hanson & Gutheil, 2004, p. 370). The following review will explore the approximate degree of alcohol misuse in older adults (current and projected), explore potential reasons for alcohol misuse in later life, review different barriers to identification and treatment, and outline older adults' unique vulnerabilities.

Review:

A problem now

There are approximately 1.4M people in the UK aged over 65 years who drink more than recommended limits (Big Lottery Fund, 2013). This would equate to a figure of around 25,000 in Wales and approximately 9,000 in Cardiff and the Vale. Some of this population would just require brief interventions and a clear understanding of the dangers of overusing alcohol. However, as around 3% of men and 0.6% of women over 65 are alcohol dependent, (NHS Information Centre, 2009) this would equate to a figure of around 350 alcohol dependent over 65's in Cardiff and the Vale. These individuals would be those requiring an intervention/treatment service and current figures would seem to suggest that the majority are not receiving this through our existing alcohol services. During 2012-2013 the total number of people aged 50 and over referred for alcohol misuse treatment in Wales was 3266; 24.4 per cent of all referrals for alcohol misuse. Over the last five years the proportion of all those referred whose main problem was with alcohol and who are aged over 50 has increased by about five per cent (Welsh Government [WG], 2014).

While these figures in themselves are worrying, there is also evidence to suggest that they probably represent a gross underestimation of the true problem. Studies consistently find that older adults are less likely to receive a primary diagnosis of alcohol dependency than younger adults (Booth, Blow, Cook, Bunn & Fortney 1992; Stinson, Dufour & Bertolucci 1989; Beresford, Blow, Brower, Adams & Hall 1988). A study of 417 patients found that junior doctors only correctly diagnosed 37% of older alcohol-dependent patients in comparison to 60% of the alcohol-dependent younger patients (Geller et al., 1989); thus supporting the notion that problematic alcohol consumption amongst older people may be "a more significant problem than has been recognised" (Royal College of Psychiatry, 2011).

A problem for the future

Alcohol consumption was less common in the 1930s, 1940s, and 1950s than it has been since the 1960s (Centre for Substance Misuse Treatment, 1998). Many of those who are currently 65 years and older, influenced by earlier cultural beliefs, never drank at all. In comparison, younger birth cohorts in this century (i.e. those born in the 1960's or later) tend to have increasingly higher rates of alcohol consumption and alcohol dependency (Atkinson, Ganzini & Bernstein, 1992), most likely related to the 'more relaxed' attitudes towards alcohol at the time in which they were born. Thus, "the prevalence of alcohol problems in old age may increase, especially among women, for birth cohorts entering their 60s in the 1990s and beyond" (Atkinson and Ganzini, 1994, p. 302).

While alcohol misuse in older populations has recently been labelled a "hidden epidemic" (Alcohol Concern, 2011), it will be increasingly difficult for older adults' alcohol misuse to remain a hidden problem as the last of the demographic bulge known as the 'Baby Boomers' approach 'old age' early in the next decade. According to recent statistics by Age UK (2013), the number of people aged 60 years and over is expected to pass the 20 million mark by 2031. More specifically, the number of people aged 65 and over is projected to rise by nearly 50% (48.7%) in the next 20 years to over 16 million.

UK life expectancy continues to increase. Current estimates at the age of 65 are 86.1 years for women and 83.5 for men (Office for National Statistics, 2013), up by 1.0 and 1.3 years (respectively) between 2010 and 2012. This increased rise in life expectancy does not just apply to non-smoking, non-drinking, healthy individuals; research has also shown that substance misusers are also living longer than ever before (Gomberg, 1992).

The ageing of the 'Baby Boomers', coupled with a rise in life expectancy, suggests that the number of older adults with alcohol-related problems will rise alarmingly. Taken together, these factors raise the prospect of tomorrow's health services facing a "potentially preventable 'tide' of alcohol-induced morbidity" (Saunders, 1994, p. 801).

Reasons for alcohol misuse in later life

As individuals get older, they often experience multiple losses, including the loss of close loved ones (bereavement), the loss of work identity (retirement), the loss of health (e.g. reduced mobility, chronic pain, etc.) and also the potential loss of personal independence (becoming a caregiver for an elderly partner/relative or in receipt of care). It is these losses, coupled with additional stressors (e.g. physical disabilities) and situational factors (e.g. altered financial circumstances), that "may result in an overwhelming situation in which alcohol misuse may begin or increase" (Wadd, Lapworth, Sullivan, Forrester & Galvani, 2011, p. 6). The continued work of Dr. Wadd and the Substance Misuse and Ageing Research Team (2014) at Bedfordshire University, led to the creation of the 'Risk and Protective Factors' illustration shown in Figure 1.

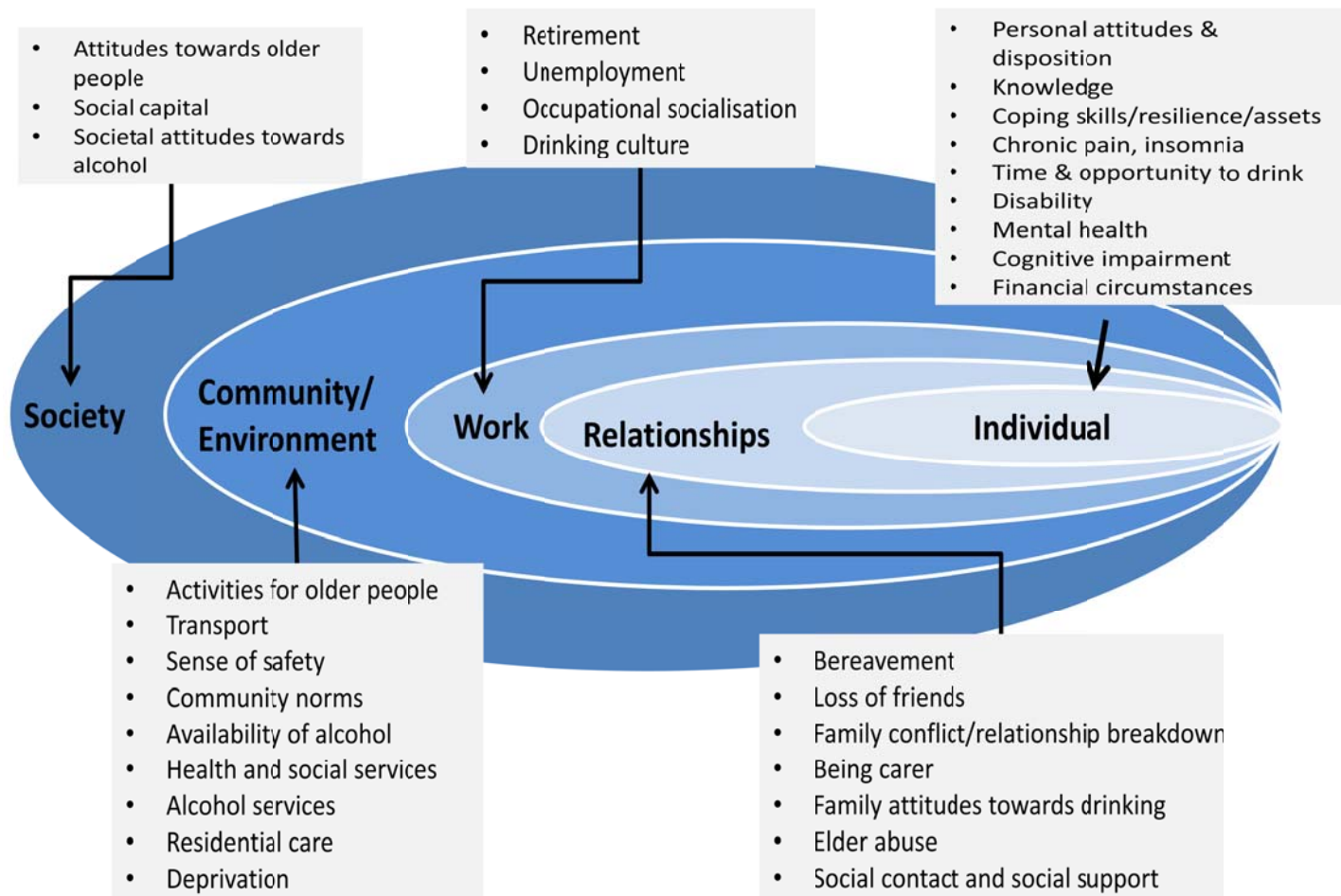


Figure 1: Risk and Protective Factors associated with alcohol consumption in later life

As highlighted within Figure 1, Wadd and colleagues (2014) propose five core elements connected with having an alcohol problem in later life (society, community/environment, work, relationships and individual) each of which comprise a number of constituent factors.

At the macro level, element 1 (society) is the most broad, reflecting that alcohol problems can stem from attitudes towards both older people and alcohol in general. The second element (community/environment) suggests that alcohol misuse can be a result of situational factors such as lack of activities for older people and availability of alcohol. The influence of changes to occupational status (including retirement and a subsequent decline in occupational socialisation/drinking culture) are categorised to form element 3 (work). Changes to relationships, whether it is the loss of family/friends or a decline in social contact/support, are grouped to form element 4 (relationships). On a micro level, the final element (the individual) outlines more personal reasons as to why older adults may drink, including: personal attitudes, finances, health deterioration and increased opportunities to drink.

It is clear to see from the Risk and Protective Factors illustration (figure 1), that there are multiple reasons as to why older adults may develop (late-onset) or increase their drinking in later life (early-onset). In some cases there may be an amalgamation of different factors from different elements that combine to cause older adults to start or increase drinking in later life; it is this multi-faceted and complex situation behind drinking which can make treatment/intervention difficult.

In an American study by Brennan, Schutte & Moos (1999), the complex two-way relationship between drinking behaviour and different types of stress (e.g. financial, health-related or emotional) was highlighted. Gender differences were found between the way in which older men and women respond to various types of stress, for example, women were likely to develop drinking problems in response to financial stresses and men were more likely to develop drinking problems as a result of stress in relationships with partners. The authors concluded that “there may be a harmful feedback cycle whereby problematic drinking and life stressors exacerbate each other, but also a benign feedback cycle in which moderate alcohol consumption and life stressors reduce each other” (p. 737).

Barriers to alcohol misuse identification and treatment

Diagnosis and treatment for alcohol misuse in older adults is far more complex than other populations, based on the range and interaction between physical and mental health problems. Some of the different barriers to effective identification and treatment include:

- Ageist attitudes
- Lack of awareness or denial
- Clinicians’ lack of, or misinterpreted, diagnosis

Ageism was first identified in the mid 1960’s (Butler, 1969) to describe the tendency of society to assign negative stereotypes to older adults and to explain away their problems as a cause of old age, rather than looking for specific psychological, social or medical explanations. The comparison between identification and treatment of alcohol misuse within older and younger adults can be used to highlight ageism. Curtis and colleagues (1989) found that younger adults – with comorbid conditions - are more likely to be examined for underlying etiologies, including that of alcohol misuse, and are also more likely to receive correct diagnosis for their alcohol misuse. With older adults however, service providers/health-care practitioners often do not look beyond the presenting problem for which the patient is seeking care (Curtis, Geller, Stokes, Levine & Moore, 1989).

Despite caregivers good intentions, instances of ageism have also been found to occur in meal settings and in the provision of services to the homebound. In one report for example, Curtis et al. (1989) found that changes in eating habits were not always explored because “older people get fussy about their food” (p.310). Confusion in older adults also went unchallenged because carers attributed the confusion to "having a bad night’s sleep" or age-related "spaciness" (p. 310).

Correspondingly, a report by the Centre for Substance Abuse Treatment (1998) highlights how younger adults often unconsciously assign different quality-of-life standards to older adults, with attitudes demonstrated by remarks such as: "Grandmother's cocktails are the only thing that makes her happy," or "What difference does it make, he won't be around much longer anyway" (p. 1). The report concluded that there is an undeclared but persistent

assumption that there is no value in treating older adults for substance misuse disorders because of low success rates and that treatment for this population is a waste of health care resources. Thus, behaviour that is considered a problem in younger adults would not appear to raise the same urgency of concern among older adults.

While these attitudes may not be direct acts of callousness on individuals' behalves, they are – and rest on – misperceptions. Hendricks, Johnson, Sheahan and Coons (1991) found that older adults who self-medicate with alcohol are more likely to report lower life satisfaction and characterise themselves as lonely; thus, grandma's cocktail may not be making her as "happy" as once initially thought. In fact, the reality is that misuse of alcohol takes a greater toll on affected older adults than it does on that of younger adults. In addition to the psychosocial issues that are distinctive to older adults, ageing also introduces biomedical changes that influence the effect that alcohol have on the body. Alcohol misuse, for example, may expedite the normal decline in physiological functioning that occurs with age (Gambert and Katsoyannis, 1995) and may elevate older adults already high risk for illness and injury (Tarter, 1995).

With such adverse risks found to be associated with drinking in later life, ageism needs to be recognised and eliminated in order to better treat harmful alcohol use in older adults. Rodeheaver (1990) suggests that in order to counteract ageism, changes must be made in the systems which maintain it. Some of the systems in this case may include: the media, popular culture, service/treatment providers and health-care professionals. For healthcare professionals in particular, it has recently been recommended that mainstream alcohol practitioners should "be aware of ageist attitudes and myths that surround alcohol misuse and become skilled at challenging them" (Wadd et al., 2011, p.26).

Lack of awareness or denial may also be barriers for identification and treatment of alcohol problems in older adults. In a guide for developing a substance awareness programme for older adults, Curie and Durham (2006) report how denial or lack of awareness is common among older adults and can be related to complex and early formed attitudes about alcohol consumption. Many older adults formed their attitudes about alcohol during the 1950s, when wider accessibility and advertising helped change the use of alcohol from a moral failing to a symbol of post war affluence. For some, alcohol misuse is not seen as a health care problem or disease; they were raised in the "well-deserved cocktail after a hard day's work" generation. Such denial, or a lack of understanding of the consequences of consuming large quantities of alcohol, can be a significant barrier to treatment (Miller & Rollnick, 1991). In particular, persons who have been consuming alcohol "successfully" for a long period of time may have difficulty recognising the increasing negative consequences of their use (Bleechem, 2002). Alternatively, they may perceive their alcohol use problems as being the result of ageing rather than comprehending the relationship between their alcohol consumption and their physical/mental health. In both situations, individuals may be opposed to entering and participating in treatment.

Many older adults are also very sensitive to the stigma associated with psychiatric disorders. They are much more willing to accept a medical diagnosis than a mental or psychiatric one and they may translate this bias into a reluctance to acknowledge symptoms or to describe mood disturbances as manifestations of weakness or irresponsibility. They may genuinely regard their problems as being simply related to old age, or they may be averse to 'complain too much' (Weiss, 1994). That said, there is a strong need to develop strategies to identify 'hidden' older problem users. One of the ways in which Wadd and colleagues (2011) recommend that this is done, is to raise awareness of the signs and symptoms amongst the general public and practitioners.

Another barrier to identification and treatment of alcohol misuse in older adults may be that of *clinician's lack of, or misinterpreted, diagnosis*. Despite its frequency, there is often a low index of suspicion for this problem, and alcohol problems in older people remain frequently undiagnosed (Wadd et al., 2011). In a relatively recent British study, Naik and Jones (1994) reported that doctors are less likely to request an alcohol history from older patients. At the same time, McInnes and Powell (1994) found that only one third of older adults admitted to hospital were correctly diagnosed as being a 'problematic drinker'. In a general hospital in the United States, Curtis et al. (1989) recorded - over a six month period - the levels of correct diagnosis for problematic drinking and found that medical staff only correctly diagnosed 37% of older patients with an alcohol problem in comparison to 60% of younger patients.

Even when there is the suspicion of an alcohol misuse disorder, practitioners may have difficulty applying the diagnostic criteria to a wide variety of nonspecific symptoms. With a younger patient, serious health diagnoses (e.g., heart disease, diabetes) can be more easily ruled out, resulting in a much quicker diagnosis of alcohol misuse in the presence of certain symptoms. With an older patient however, practitioners face the problem of having symptoms such as fatigue, irritability, insomnia, chronic pain or impotence, all of which may be produced or influenced by alcohol misuse, common medical and mental disorders, or a combination of these conditions. Thus, it is difficult to differentiate the symptoms of alcohol problems in older people from the symptoms caused by the medical or psychiatric problems of ageing (Thibault & Maly, 1993).

Other barriers related to clinician behaviour are also noted in the literature. Keeler, Solomon, Beck, Mendenhall and Kane (1982) studied the relationship between a patient's age and length of physician encounter and found that as age increased, the length of time physicians spent with the patient decreased. According to the report by the Centre for Substance Abuse Treatment (1998), not only does the length of time spent with the physician decrease but less time is spent discussing alcohol related problems as providers, older patients and family members typically place higher priority on physical conditions (such as heart problems and renal failure) than on alcohol misuse. Alcohol misuse often

ends up at the bottom of the list or is not considered at all when a patient presents with many medical or personal problems.

Detection of alcohol dependency in older adults may not just be hindered by time constraints, it may also be thwarted by a lack of awareness amongst professionals that alcohol is a potentially important problem for older people. Research by Mellor and Garcia (1996) suggests that health and social care workers regularly take the stance that older adults are 'too old to learn something new', especially when behaviour is required to change. It is these types of ageist attitudes that could prevent older adults from being offered the full choice of treatment options (Wadd et al., 2011). Correspondingly, Curtis and colleagues (1989) found that, in comparison to younger populations, older adults are less likely to have specialist alcohol treatment recommended or initiated by practitioners. Moos, Mertens and Brennan (1993) found that older adults are more likely to receive medical attention for health-related effects of alcohol, rather than treatment for the alcohol problem itself; despite the fact that older people are more receptive to alcohol treatment than younger populations (Oslin, Pettinati & Volpicelli, 2002) and are just as likely to benefit from it (Lemke & Moos 2003).

There appears not only to be an underestimation of rates of alcohol misuse in older adults but also a lack of understanding of the effects (primarily that of beneficial ones) that treatment can have for older adults with alcohol problems. As suggested earlier by the Centre for Substance Abuse Treatment (1998) – a statement which would appear to remain pertinent today - “health care providers need more education about substance abuse treatment options and success rates” (p.7, chapter 1.)

Unique health considerations for older adults

As a result of physiological changes brought about by the ageing process, there are substantial differences between an older and a younger adult's response to alcohol. To be more specific, there are three age-related changes which have been shown to significantly affect the way an older person responds to alcohol:

- Decrease in body water
- Increased sensitivity and decreased tolerance to alcohol
- Decrease in the metabolism of alcohol in the gastrointestinal tract

As lean body mass decreases with age, total body water also decreases, while fat increases. Because alcohol is water-soluble and not fat-soluble, this change in body water means that, for a given dose of alcohol, the concentration of alcohol in the blood system is greater in an older person than in a younger person. For this reason, the same amount of alcohol that previously had little effect can now cause intoxication (Smith, 1995; Vestal, McGuire, Tobin, Andres, Norris & Mezey, 1977).

This often results in increased sensitivity and decreased tolerance to alcohol as people age (Rosin & Glatt, 1971). Researchers speculate that the change in relative alcohol content combined with the slower reaction times frequently observed in older adults may be responsible for some of the accidents and injuries that affect this age group (Bucholz, Sheline & Helzer, 1995; Salthouse, 1985; Ray, 1992).

The decrease in gastric alcohol dehydrogenase enzyme that occurs with age is another factor that exacerbates problems with alcohol. This enzyme plays a key role in the metabolism of alcohol that occurs in the gastric mucosa. With decreased alcohol dehydrogenase, alcohol is metabolised more slowly so the blood alcohol level remains raised for a longer time. With the stomach less actively involved in metabolism, an increased strain is also placed on the liver (Smith, 1995).

In addition, other comorbid factors found to be associated with alcohol dependency in older adults include those of: increased risk of hypertension, cardiac arrhythmia, myocardial infarction, cardiomyopathy (McKee & Britton, 1998), memory loss, self neglect, depression (Woodhouse, Keatinge & Coleshaw, 1989), incontinence and gastrointestinal problems (Tabloski & Church, 1999), impaired immune system and capability to combat infection and cancer (Kovacs & Messingham, 2002), dementia (Hislop et al., 1995), malnutrition (Gambert, 1992) and Parkinson's disease (Feuerlein & Reiser, 1986).

Other biomedical changes of ageing are cognitive impairments, which are both confused with and worsened by alcohol use. Chronic alcohol misuse can cause serious, irreversible changes in brain function, although this is more likely to be seen in older adults with a long history of alcohol dependency (Oscar-Berman & Marinkovic, 2003). Alcohol use may have direct chemical neurological effects, leading to a characteristic syndrome called Alcohol-Related Dementia (Gupta & Warner, 2008). There is also evidence to suggest that alcohol use may be associated with the development of other dementing illnesses including that of Wernicke's Encephalopathy and/or Korsakoff's Syndrome (Chiang, 2002; Day et al., 2008).

Alcohol Related Brain Damage (ARBD) is the over-arching term used to describe the effects of long term alcohol consumption on the function and structure of the brain. While some argue that it can be divided into a number of categories including that of Wernicke-Korsakoff's Syndrome, Alcohol-Related Dementia and Alcohol Amnestic Syndrome, other researchers have argued that ARBD is really a spectrum of disorders (including the three above) which combine and overlap each other (Jacques & Stevenson, 2000).

One thing that is not disputed between researchers is the cognitive and physical problems associated with ARBD. Cognitive and memory problems include confusion about time/place, poor concentration, difficulty processing new information, depression and irritability. Physical problems include poor balance, damage to liver, stomach and pancreas, damage to brain by toxins normally removed by the liver, damage to the part of the brain that controls coordination and balance and brain injury as a result of falls/fights.

Whilst the traditional representation of someone whose mental capacity has been impaired by alcohol is that typically of an elderly homeless male, the reality is somewhat different. In 2004, the Scottish Executive's Expert committee revealed that people affected by ARBD are a diverse group in terms of age, age of onset of ARBD, gender, general lifestyle including drinking history and employment, social networks, family structure, cultural/spiritual background, presence of other mental health problems, physical/learning disabilities and neurological/medical conditions (Cox, Anderson & McCabe 2004). Thus, it is not just the stereotypical norm of male street drinkers who suffer from ARBD. In support of this argument, a recent report by Alcohol Concern (2014) highlights how there is a "general reluctance to recognise that problem drinkers are not bizarre outliers, but rather members of a drinking society that includes the vast majority of us" (p. 7). Alcohol Concern goes on to argue that ARBD is poorly understood by the public and is underdiagnosed and undertreated. In order to address the current issues relating to ARBD in Wales, Alcohol Concern recommends that "work is needed to raise awareness amongst the general population, as well as health and social care professionals" (p. 14).

Summary

As highlighted at the start of this review, 3% of men and 0.6% of women over 65 are alcohol dependent, (NHS Information Centre, 2009); this would have then equated to a figure of around 350 alcohol dependent over 65's in Cardiff and the Vale. While these figures are not doubted, current estimates specific to Cardiff and the Vale are unknown. There is evidence to suggest that such figures probably represent a gross underestimation of the true problem; particularly given the different barriers to identification and treatment. The ageing of the 'baby boomers', coupled with a rise in life expectancy, further suggests that the number of older adults with alcohol-related problems will rise alarmingly. Thus, alcohol is not just a problem for some older adults now but will continue to be an increasing problem for the future.

Research intent

At present, current literature on alcohol and older people is very much dependent on American and/or Australian research; this is clearly demonstrated throughout the literature review. With diverse cultural norms and different recommended daily limits based around alcohol, more UK based research is undoubtedly needed before definitive conclusions and generalisations can be drawn specific to local regions. As well as identifying current estimates of problematic drinking in older adults specific to Cardiff and the Vale, this research aims to address: numbers accessing/not accessing services, current services available and their effectiveness for older adults, barriers to engagement and what older adults, service providers and health care practitioners feel is needed.

A full list of project aims can be found on page 19.

Project aims

This research and scoping project aimed to collect data based on the following information:

- Levels of harmful and problem drinking amongst those 60 years and over living in Cardiff and the Vale;
- Numbers accessing help from substance misuse services and their views on how appropriate these services are for their needs;
- Numbers accessing other services where alcohol is an issue but no intervention has happened and why;
- What are the barriers to engagement for those not accessing services;
- Socio-economic status of older drinkers;
- Current levels of harm/health problems related to alcohol;
- What training or awareness-raising requirements do non-specialist practitioners feel would help them recognise alcohol issues and what they could do to support individuals;
- What service providers/practitioners feel is needed;
- How best to ensure older people and their families get accurate, accessible information about alcohol use.

Methodology

In order to collect information that met each of the project aims (see page 19 for full list), a mixed method approach (of quantitative and qualitative data) was undertaken.

Materials

Questionnaire for older adults (AUDIT)

In order to collect data on...

- Levels of harmful and problem drinking amongst those 60 years and over
- Numbers currently accessing services and their views on how appropriate these services are for their needs
- Barriers to engagement for those not accessing services
- Socio-economic status of older drinkers

...an online questionnaire was created using Survey Monkey software. The same questionnaire was also created and made available as a paper version (see appendix 1). The questionnaire comprised a total of 20 questions, some of which were multiple choice (quantitative in design) and some of which were open ended (qualitative in design). Questions included: general demographics (age, gender, annual household income and first half of postcode), the Alcohol Use Disorders Identification Test (AUDIT) which is comprised of 10 items, ratings of any services accessed and barriers to engagement for potential service users.

Interviews with older adults

As part of the qualitative approach to understanding the personal experiences/opinions of older people and alcohol a semi-structured interview schedule was created.

Theme 1 included questions based around general drinking lifestyle (e.g. *“Do you drink?”*; *“How much do you drink?”* and *“Is your current level of drinking something you are happy with, or would you like it to change and why?”*). Theme 2 included questions based around reasons for drinking (e.g. *“Why do you drink?”*). Theme 3 included questions based around help and services (e.g. *“Do you receive any help with your current level of drinking...?”* and *“...If so, what are your general perceptions of this help/service/intervention?”*). And finally, theme 4 included questions based around the effects of drinking (e.g. *“Has drinking affected your health physically or mentally in any way?”*).

This semi-structured schedule allowed for some consistency of questions asked across different interviews, but flexibility was given based on the individual, their circumstances and the answers which they provided. For a full list of questions included in this semi-structured interview schedule, see appendix 2. Interviews were audio taped, transcribed

and analysed using a thematic analysis approach. To ensure the anonymity of the older people interviewed, names and identifying information were changed.

Questionnaire for service providers/practitioners

In order to collect data on...

- Numbers currently using services
- Numbers receiving other services where alcohol is an issue but no intervention has happened and why
- Current levels of harm/health problems related to alcohol
- What training or awareness-raising requirements do non-specialist practitioners feel would help them recognise alcohol issues and what they could do to support individuals
- What service providers/practitioners feel is needed

...an online questionnaire was created using Survey Monkey software. The same questionnaire was also created and made available as a paper version (see appendix 3). The questionnaire comprised a total of 9 questions, some of which were multiple choice (quantitative) and some of which were open ended (qualitative in design). Questions included: frequency of contact with older problem drinkers and experiences of this client group, physical, health, and mental health problems related to alcohol and older people, experience of drunken behaviour and day-to-day implications of drinking, awareness of local services/interventions and ratings of those outlined and personal opinions on what alternative services and/or information is needed.

Interviews and focus groups with service providers/practitioners

A qualitative approach was employed in order to understand the experiences/opinions of different service providers/practitioners on the subject matter of alcohol and older people. Prior to conducting the interviews/focus groups, a semi-structured interview schedule was created to allow for some consistency of questions asked across the board.

Theme 1 included questions based around general experiences of problem drinking in older adults (e.g. *In your role, how often do you come into contact with older problem drinkers?*) and *“Approximately what percentage of your client group has identified problem drinking?”*). Theme 2 included questions based around the impact of problem drinking (e.g. *“Do you see alcohol related physical injuries?”*). Theme 3 included questions based around assessment, screening and interventions (e.g. *How do you assess/screen for problem drinking in older adults*” and *“what interventions – if any – do you provide for older adults with identified drinking problems?”*). Theme 4 included questions based around awareness of local services/interventions (e.g. *“what kinds of services are you aware of locally that support older problem drinkers?”* and *“what additional/alternative services/interventions do you feel are need to support older problem drinkers?”*). Theme 5 included questions based

around training and professional development (e.g. *“please describe any training you/your team have received regarding alcohol and older people”* and *“are there areas you feel you need further training/mentoring in this area?”*). The last theme, general perceptions, gave service providers/practitioners the opportunity to add anything they wished around the subject matter of alcohol and older people.

Interviews and focus groups were not restricted solely to local alcohol-specific services, but were also conducted with non alcohol-specific services (e.g. older person’s social care team, Newydd housing support, Diverse Cymru and Cardiff Police). This approach allowed for a broad picture of ‘what’s going on’ in Cardiff and the Vale; that is, numbers receiving other services where alcohol is an issue but no intervention has happened and why (addressing aim 3). For a full list of questions included in this semi-structure interview schedule, see appendix 4. Interviews/Focus Groups were audio taped, transcribed and analysed using a thematic analysis approach. Individual names of service employees/practitioners have been removed to ensure anonymity of responses given.

Results from Older Adults

Questionnaire data

A total of 288 older adults completed the older adult questionnaire. Of these, 207 were female and 81 were male. Mean age for male participants was 72.5 years and mean age for female participants was 73.3 years. Overall mean age (for all participants) was 73 years. 98 questionnaires were completed online (via Survey Monkey) and the remaining 190 completed paper copies (sent to The Wallich or collected by the researcher).

Postcode breakdown:

As can be seen in figure 2, of the 96.5% who supplied this information, the majority of participants who completed the older adults' questionnaire lived in Cardiff West (N=66), Cardiff South (N=63), Cardiff North (N=40) and Barry (N=40). For a full breakdown of postcode areas, see appendix 8.

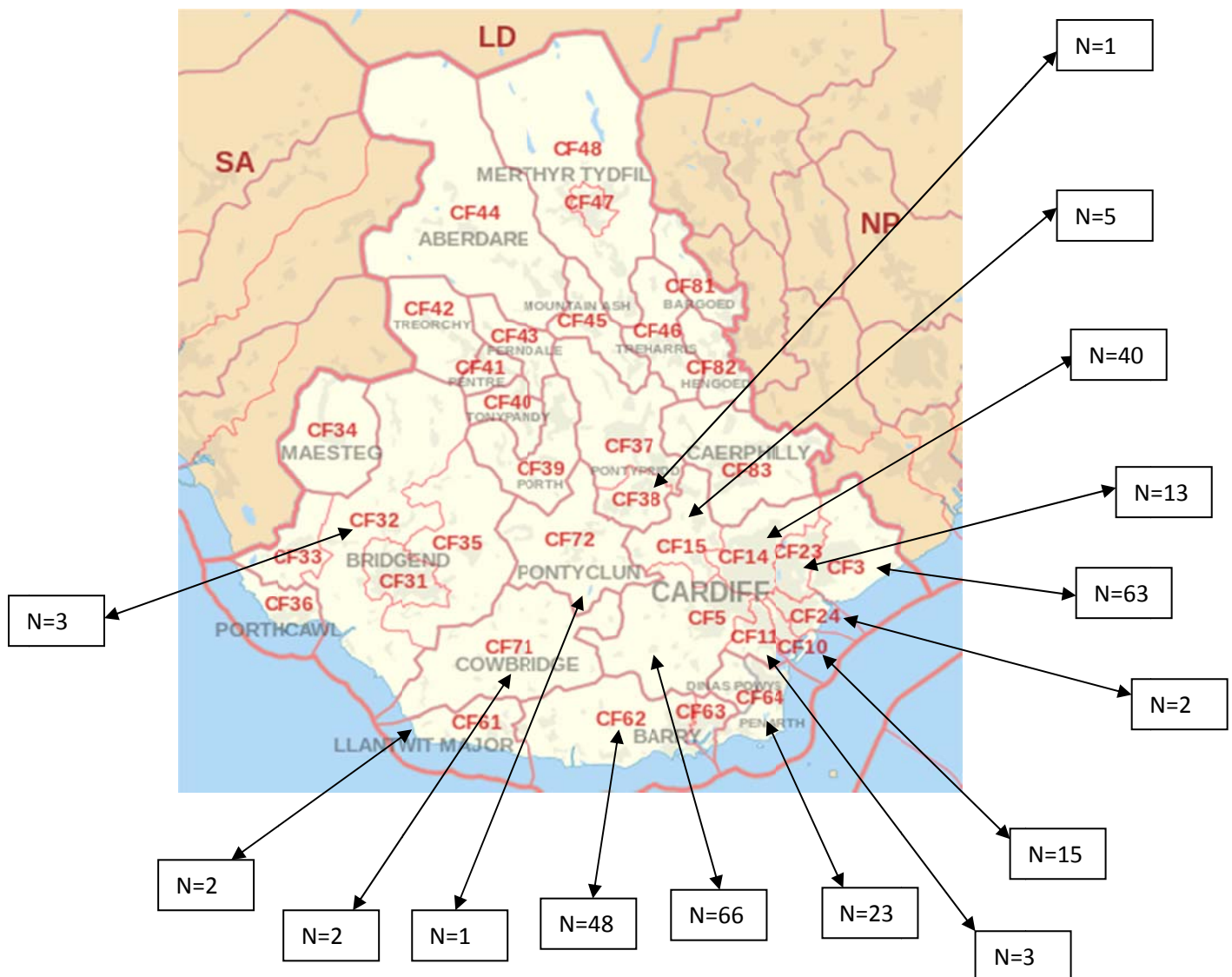


Figure 2: Postcode breakdown

AUDIT (overall scores)

The Alcohol Use Disorders Identification Test (AUDIT) was the measure used to identify persons with hazardous and harmful patterns of alcohol consumption. Range of scores can fall between 0 (being the lowest) and 40 (being the highest), and participants are categorised, based on their score, as needing one type of intervention. Score categorisation was as follows:

Table 1: AUDIT categorisation of scores

<u>Risk level</u>	<u>Intervention</u>	<u>AUDIT score</u>
Zone I	Alcohol Education	0-7
Zone II	Simple Advice	8-15
Zone III	Simple Advice plus Brief Counselling and Continued Monitoring	16-19
Zone IV	Referral to Specialist for Diagnostic Evaluation & Treatment	20-40

Of the 288 older adults who completed the older adults' questionnaire:

87.8% (N=253) scored as 7 or less – alcohol education

8.3% (N= 24) scored 8-15 – simple advice

.3% (N= 1) scored 16-19 – simple advice & brief counselling with continued monitoring

3.5% (N=10) scored 20-40 – referral to specialist for diagnostic evaluation and treatment

Although 3.5% may initially not be regarded as significant, when extrapolating this figure to the population of older adults (60 years +) living in Cardiff and the Vale, which has been shown to total 95,493 (see page 8) this figure equates to 3,342. Thus, from these results, it can be inferred that **3,342 older adults living in Cardiff and the Vale have hazardous and harmful patterns of alcohol consumption** to the point that they should be referred to a specialist for diagnostic evaluation and treatment.

AUDIT (gender differences)

When overall AUDIT scores were considered for male and female participants separately, 7.4% of males were categorised as Zone IV (referral to a specialist), in comparison to 1.9% of females who categorised as Zone IV (referral to a specialist). From this, an Independent T-Test analysis was run to explore whether the difference between male and female AUDIT scores was significant, and revealed that males did in fact score significantly higher on the AUDIT scale than females ($t=3.103$, $df=286$, $p=.002$); therefore suggesting that **males are significantly more likely to have hazardous and harmful patterns of alcohol consumption than females.**

AUDIT (sub-domain scores)

As well as being able to calculate an overall AUDIT score, the AUDIT measure comprises three sub-domains (hazardous alcohol use, dependence symptoms and harmful alcohol use). By calculating and coding participants' scores on questions relevant to each of these, scores can be obtained for each of the three sub-domains. See appendix 5 for SPSS output data

Table 2: Sub-domains and item content of the AUDIT

<u>Sub-domain</u>	<u>Question number</u>	<u>Item content</u>
Hazardous alcohol use	1	Frequency of drinking
	2	Typical quantity
	3	Frequency of heavy drinking
Dependence symptoms	4	Impaired control over drinking
	5	Increased salience of drinking
	6	Morning drinking
Harmful alcohol use	7	Guilt after drinking
	8	Blackouts
	9	Alcohol-related injuries
	10	Others concerned about drinking

When participants' scores were calculated for the sub-domain 'hazardous alcohol use', 17.7% of participants were categorised as having a medium to high hazardous alcohol use score. When extrapolated to the general population of older adults (60 years +), living in Cardiff and the Vale, this 17.7% equates to 16,910. From this it may be inferred that **a significant number of older adults (approximately 16,910) have hazardous alcohol use and require advice and guidance based around recommended limits (frequency, quantity and effects of heavy drinking).**

- When female and male scores were analysed separately, 29.63% of males were categorised as having a medium to high hazardous score in comparison to 13.04% of female participants. These figures, when extrapolated, suggest that 12,672 of older males, living in Cardiff and the Vale, engage in hazardous alcohol use, in comparison to 6,876 of older female residents.

When participants' scores were calculated for the sub-domain 'dependence symptoms', 3.4% of participants were categorised as having medium to high dependency symptoms. When extrapolated to the general population of older adults (60 years +) living in Cardiff and the Vale, this 3.4% equates to 3,246. From this it may be inferred that **approximately 3,246 older adults, living in Cardiff and the Vale, have dependence symptoms including impaired control over drinking, increased salience of drinking and morning drinking.**

- When female and male scores were analysed separately, 6.1% of males were categorised as having a medium to high dependency score in comparison to 2.4% of female participants. These figures, when extrapolated, suggest that 2,608 of older males living in Cardiff and the Vale have dependence symptoms in comparison to 1,265 of older female residents.

When participants' scores were calculated for the sub-domain 'harmful alcohol use', 4.1% of participants were categorised as having medium to high harmful alcohol use. When extrapolated to the general population of older adults (60 years +) living in Cardiff and the Vale, this 4.1% equates to 3,915. From this it may be generalised that **approximately 3,915 older adults, living in Cardiff and the Vale, have harmful alcohol use, including: guilt after drinking, blackouts, alcohol-related injuries and concern from relatives, practitioners and/or social care workers.**

- When female and male scores were analysed separately, 7.4% of males were categorised as having medium to high harmful alcohol use in comparison to 2.9% of female participants. These figures, when extrapolated, suggest that 3,164 of older males living in Cardiff and the Vale have harmful alcohol use in comparison to 1,528 of older female residents.

AUDIT (individual question analysis)

Individual analyses were also run on each of the 10 questions comprising the overall AUDIT measure.

For question 1 (frequency of drinking), 14.9% reported never drinking at all, 26% reported drinking monthly or less, 20.5% reported drinking 2-4 times a month, 17.7% reported drinking 2-3 times a week and **20.8% reported drinking 4 or more times a week**. This 20.8%, when extrapolated to older adults living in Cardiff and the Vale, equates to 19,862. From this it may be suggested that **a significant number (approximately 19,862) of older adults drink alcohol on 4 or more occasions each week.**

- When responses from male and female participants were considered separately, 30.9% of males reported drinking the highest choice of 4 or more times a week in comparison to 16.9% of female participants reporting that limit. These figures, when extrapolated, might suggest that 13,215 of older males, living in Cardiff and the Vale, drink more than 4 times a week, in comparison to 8,910 of older female residents

For question 2 (typical quantity), 74.3% of participants reported drinking 1-2 drinks on a typical day, 18.1% reported drinking 3 or 4 drinks on a typical day, 5.2% reported drinking 5 or 6, 0.7% reported having 7-9 drinks on a typical day and 1.7% reported drinking 10(+) drinks on any typical day. This, when compared against the daily recommended limits (see page 8), suggests that **25.9% of the sample group drink more than the daily recommended limits on any typical day in which they have a drink**. What's more, this 25.9%, when extrapolated to older adults living in Cardiff and the Vale, equates to 24,732, thus inferring that **a considerable portion of older adults drink more than recommended daily limits.**

- When responses from male and female participants were considered separately, 30.8% of males reported drinking more than the recommended daily limits on any typical drinking day, in comparison to 23.8% of female respondents. These figures, when generalised, suggest that 13,173 of older males living in Cardiff and the Vale drink more than the daily recommended limits compared to 12,548 of older female residents.

For question 3 (frequency of heavy drinking), 3.5% of respondents reported having 5 or more drinks on any one occasion on a daily or almost daily basis. This 3.5%, when generalised to older adults living in Cardiff and the Vale, equates to 3,342, thus suggesting that **a significant portion of older adults have a high frequency of heavy drinking.**

- When responses from male and female participants were considered separately, 7.4% of males reported having 5 or more drinks on any one occasion (on a daily or almost daily basis), in comparison to 1.9% of female respondents. These figures, when extrapolated, suggest that 3,164 of older males living in Cardiff and the Vale have a high frequency of heavy drinking in comparison to 1,001 of older female residents.

For question 4 (impaired control over drinking) 3.1% of the sample group reported that they, daily or almost daily, found that they were not able to stop drinking once they had started. This 3.1%, when extrapolated to older adults living in Cardiff and the Vale equates to 2,960 therefore suggesting that **a noteworthy proportion of older adults have impaired control over their drinking.**

- When responses were considered separately for male and female respondents, impaired control over drinking was found to be the case for 4.9% of male respondents and 1% of female respondents. These figures suggest that 2,095 older males living in Cardiff and the Vale have impaired control over their drinking compared to 527 older female residents.

For question 5 (increased salience of drinking) 1.4% of the sample group reported failing to do what was expected of them on a daily or almost daily basis because of drinking. This 1.4%, when generalised to older adults living in Cardiff and the Vale, equates to 1,336, suggesting that **a large proportion of older adults fail to do what was expected of them (on a daily or almost daily basis) because of drinking.**

- When responses were considered separately for male and female respondents this was found to be the case for 4.9% of male participants in comparison to 0% of female participants. These figures, when extrapolated, suggests that 2,095 of older males, living in Cardiff and the Vale, have difficulty doing what is expected of them (on a daily or almost daily basis) because of alcohol.

For question 6 (morning drinking) 1% of the sample group reported having a morning drink on a monthly or weekly basis. What's more, 1% of the sample group reported having a morning drink on a daily or almost daily basis. Although small, this 1%, when extrapolated to older adults living in Cardiff and the Vale, equates to 954 thus suggesting that **a noteworthy proportion of older adults have a morning drink on a daily or almost daily basis.**

- When responses were considered separately for male and female participants, this was found to be the case for 6.1% of male participants in comparison to 0.5% of female participants. These figures, when generalised, infer that 2,608 of older males, living in Cardiff and the Vale, have a drink in the morning (on a daily or almost daily basis) as do 263 female residents.

For question 7 (guilt after drinking) 8.6% of the sample group reported having experienced some feeling of guilt after drinking (be it less than monthly, monthly, weekly or daily). Of this, 2.1% reported feeling guilty (on a daily or almost daily basis) after drinking. This 8.6%, when generalised to older adults living in Cardiff and the Vale, equates to 8,212, thus suggesting that **a significant portion of older adults feel guilty after drinking.**

- When responses were considered separately for male and female participants, 3.7% of male responses indicated feeling guilty on a daily or almost daily basis in comparison to 1.4% of female responses. These figures, when extrapolated, suggest that 1, 582 of older males, living in Cardiff and the Vale, feel guilty after drinking in comparison to 738 female residents.

For question 8 (blackouts) 6.9% of the sample group reported having experienced a blackout at some point in time (be it less than monthly, monthly, weekly or daily). Of these, 1.7% reported blackouts on a daily or almost daily basis. This 6.9%, when extrapolated to older adults living in Cardiff and the Vale, equates to 6,589, signifying that **a considerable proportion of older adults have experienced a blackout at some point as a result of drink.**

- When responses were considered separately for male and female participants, 4.9% of male respondents reported blackouts on a daily or almost daily basis in comparison to .5% of female participants. These figures suggest that 2,095 of older males, living in Cardiff and the Vale, have had a blackout as a result of drink as have 263 female residents.

For question 9 (alcohol-related injuries) 7% of the sample group reported themselves or someone else as having been injured because of their drinking. 1.4% reported themselves, or someone they know, being injured in the last year as a result of their drinking. This 7%, when extrapolated to older adults living in Cardiff and the Vale, equates to 6,684, suggesting that **a significant proportion of older adults have themselves, or know someone who has, been injured as a result of their drinking.**

- This was the case for 12.3% of males, in comparison to 5.3% of female respondents. These figures suggest that 5,260 older males, living in Cardiff and the Vale, have themselves, or know someone who has, been injured as a result of their drinking. The figure for women, when extrapolated, is 2,266.

For question 10 (others concerned about drinking) 6.6% of the sample group reported that a relative, friend, doctor or health care worker has been concerned about their drinking. Of this, 3.8% reported how someone had been concerned about their drinking in the last year. This 3.8%, when extrapolated to older adults living in Cardiff and the Vale, equates to 3,628, thus suggesting that **a large proportion of older adults have had someone acknowledge concerns about their drinking.**

- Of the sample group 12.3% of male respondents reported having had someone been concerned about their drinking in comparison to 4.3% of female respondents.

For raw SPSS output data, see appendix 5.

Summary of AUDIT findings (key points):

- 3.5% of the sample group scored the highest band on the AUDIT scale suggesting that they need referral to a specialist for diagnostic evaluation and treatment. This, when extrapolated to the number of older adults (60 years +), living in Cardiff and the Vale, equates to 3,342, thus suggesting that there is a significant number of older adults with hazardous and harmful patterns of alcohol consumption living within Cardiff and the Vale.
- Males were found to score significantly higher on the AUDIT measure than females and are more likely therefore to have hazardous and harmful patterns of alcohol consumption.
- When sub-domains of the AUDIT measure were considered separately, 17.7% of the sample group were found to score between medium to high on 'hazardous alcohol use'. This, when generalised to the number of older adults (60 years +) living in Cardiff and the Vale, equates to 16,902 suggesting that there is a significant proportion of older adults who require advice or guidance based around recommended limits (frequency, quantity and effects of heavy drinking).
- Males were found to have significantly higher hazardous alcohol use scores than females.
 - It could be inferred from this that males specifically need to be targeted in terms of advice or guidance based around recommended limits (frequency, quantity and effects of heavy drinking).
- 20.8% of the sample group reported drinking on 4 or more occasions each week. In addition, 25.9% of the sample group drink more than the daily recommended limits on any typical day in which they do have a drink. This, when extrapolated to the number of older adults (60 years +) living in Cardiff and the Vale, equates to 24,737, thus signifying that there is a significant number of older adults who drink more than the daily recommended limits.
 - This reinforces the notion that more advice and guidance is needed around recommended limits (frequency, quantity and effects of heavy drinking).

Socio-economic status of older drinkers

The gauge used to determine socio-economic status of individuals was annual household income. Participants were asked “which of these best describes your annual household income” and provided with four follow up options (£0-£24,999, £25,000-£49,999, £50,000-£99,999, £100,000-£149,000 or £150,000+). Results (generally and alcohol related) were as followed:

General

75.0% (N=216) had an income of less than £25,000

19.4% (N=56) had an income of between £25,000-£49,999

3.1% (N=9) had an income of between £50,000 - £99,999

2.4% (N=7) had an income of between £100,000 +

Alcohol related

On analysis, 4.6% of participants who had an income of between £0 - £25,000, were found to require referral to a specialist for diagnostic evaluation and treatment. No participants from any of the higher income bands were categorised as needing this treatment from analysis of overall AUDIT scores. 0.5% of this same income group (£0 - £25,000) were categorised as needing simple advice, brief counselling and continued monitoring. Again, no-one in the higher income bands were categorised as needing this treatment from analysis of overall AUDIT scores. The only treatment required (according to analysis of AUDIT scores and categorisation based on this) was that of alcohol education and simple advice; the two lowest levels of treatment interventions. This would suggest that alcohol misuse is more likely to occur within individuals with lower socio-economic status (income). That said, caution does need to be exercised with regards to this finding given the high percentage of participants (75%) who fall into the lower income bracket. In order for this conclusion to be drawn more definitively, future research would need more equally weighted sample groups across all socio-economic (income) bands.

Most frequently reported types of drinks consumed

Wine was the most frequently reported drink consumed with 55.9% (N=162) of participants reporting to drink this. The second most popular drink reported to be consumed was beer with 50 participants (17.4%) selecting this. 49 participants (17%) reported drinking whisky. 8.7% of participants (N=17%) reported drinking Brandy, as did the same amount (17%) report drinking vodka.

A full list of drinks and accompanying percentages can be found in appendix 6.

Reasons for drinking

In terms of reasons for drinking, loneliness was the most frequently reported reason by older adults, demonstrated in examples such as *“living on your own with no one to talk to is a contributing reason”* and *“if you live on your own, who is there to care?”* For some individuals, this loneliness was the result of losing a close loved one *“I cannot answer for others but I myself could find myself taking to the bottle and drinking to drown my sorrows, having lost my beautiful wife Dilys of 54 years, 6 years ago...a massive hole had been left in my life”*. As a result, drinking was taken up as a coping mechanism for loneliness *“For many people they feel that, having the prop of alcohol, they can cope with being lonely or unnecessary to the younger world around them”*.

For some individuals drinking is a positive experience offering an increased social life: *“I like to go to the pub and have a couple of beers with my friends, it keeps my head screwed on”*; *“If I didn’t go to the pub, I probably wouldn’t see anybody for weeks.”* For these individuals alcohol serves as a way of staying connecting to others as opposed to those in the first cohort who drink as a form of escapism from loneliness.

Another frequently reported reason for drinking was that of pain-management: *“it helps me with my pain”*; *“if I didn’t have a drink then I would be in a lot more pain than I am when I have a drink”*. Some older adults also mentioned how they felt drinking alcohol was good for their health/well-being: *“a glass of wine a day is good for your health”*; *“drinking helps me sleep at night.”*

Older adults receiving help

Of the sample, 3 participants (1.03%) reported receiving some form of help for their level of alcohol consumption. One participant (identified as participant 197) stated that they receive help from Vale Alcohol and Drug Team and marked the help they receive as being *“very good”*. Participant 130 stated that they are *“attending regular sessions of relaxation and counselling”* and that this has been, and continues to be, *“an immense support for them”*. The third and final participant (identified as participant 162), receives help from *“Barry, Newlands”* and states that the *“effectiveness is very good.”* Whilst the quantitative nature of the questionnaire did not really allow for lengthy responses regarding service provision/effectiveness, the responses from participants who are receiving some form of treatment/help from service(s) are clearly that of positive experiences.

When this figure of 1.03% (3 participants) is compared against the results of overall AUDIT scores, which highlight a much greater need for older adults to receive some form of treatment, it can be concluded that a large portion of older adults in this sample group (and extrapolated to the wider population of older adults living in Cardiff and the Vale) are not seeking/receiving help for their current level of alcohol consumption. From this, barriers to engagement were explored.

Barriers to engagement

In order to explore potential barriers to engagement, participants were asked: 'In your opinion, what are the reasons as to why some older adults with problem drinking may not seek help from local services?' From this, numerous barriers to engagement were identified.

The most commonly identified barrier to engagement was that of shame and embarrassment. This is represented in quotes such as: "*in my experience it is a sense of shame, of letting others know you have a problem*" and: "*they are embarrassed about having a drinking problem*". This finding is consistent with earlier research by Wadd et al., (2011) in which embarrassment and shame were found to prevent some individuals accessing services/treatment.

Another barrier to engagement that was identified by older adults was that of denial or a lack of understanding that they might have a drink problem. Quotes such as: "*they will not let themselves believe that they need help*" and "*don't see drinking one or two drinks each evening as a problem – it's normal*" demonstrates this. For others they realise that they are drinking too much, but the experience of alcohol is regarded as positive and subsequently they do not want to stop/change: "*I know that I drink too much but I really don't want to change*"; "*it's a way of relaxing and socialising*". This finding supports earlier research by Curie and Durham (2006) in which it is reported that denial or lack of awareness is common amongst older adults and can be related to complex and early formed attitudes about alcohol consumption.

Some older adults comment on the types of services available and how the 'age appropriateness' of these may act as a barrier: "*services not seen as appropriate for older adults- geared towards younger adults*"; "*services seen as for younger people*". In addition to the services not seen as age-appropriate, some older adults comment on the age-appropriateness of the employees offering help: "*...resent being helped by someone younger, 'what do they know that I don't?'*". More worryingly, some older adults stated that they were unaware of any help available to them: "*...not aware of the help that is available*".

Ageist attitudes were also highlighted within some of the responses from older adults: "*Older people alcoholic longer, very hard to change. Single older people more so...*" This finding supports earlier literature on ageism which suggests that people have different attitudes towards older adults than they do towards younger individuals (Curtis et al., 1989). What is interesting is that this ageist comment came from an older adult and therefore suggests that ageist attitudes do not only reside within younger populations, health care practitioners and/or social care workers (as outlined within the literature review) but they can also be inherent in older adults themselves.

Interview data

A total of four older adults took part in a short interview with the lead researcher. Of these, two were female and two were male.

(Note: Names have been changed for anonymity purposes).

Drinking lifestyle: The cultural norm

Although the experiences and drinking lifestyles for the four participants interviewed were very diverse from each other, one common theme that ran throughout the interviews was that of how alcohol consumption was very much the cultural norm for them in their “*heyday*”. This theme is clearly expressed in quotes such as: “*culturally, boozing is so much a part of my era...alcohol was what we did, we all drank*” [interview 4] and: “*I suspect it’s a culture thing...it’s something that my parents generation would have treated as normal... but now today you don’t have that kind of culture, but people like me, I guess, have continued with it*” [interview 1]. This finding supports the notion that drinking, and attitudes towards drinking, can stem from cultural norms and beliefs; it is these cultural norms and attitudes which therefore need to be challenged if any positive action is going to be taken towards current levels of problematic alcohol consumption in older adults.

Reasons for drinking: A coping mechanism

Another common theme from the interviews with older adults was that of how alcohol served as a coping mechanism from feelings of loneliness and/or a lack of self-worth. For Mary’s friend alcohol consumption was augmented when she moved to a new country (following the war) and was left alone and subsequently lonely: “*Drinking was so much a part of her life and it was only when she was left along a lot, in London you see, she didn’t have anyone there...*” [interview 2]. For John, alcohol served as escapism from feelings of a lack of self-worth, subsequent to losing his job: “*I was so ashamed...I had lost my identity...the thing to keep me occupied was to get stoned or get drunk*” [interview 4]. Thus, be it a result of loneliness, losing a job, feelings resultant from that or other individual reasons, alcohol is evidently used as a form of escapism. It is these underlying reasons which need to be addressed and treated accordingly so that alcohol is not the coping mechanism used to escape. These findings, in terms of reasons for drinking, support that of the quantitative results outlined earlier (page 29).

Interview 1: Brief synopsis

Paul is in his 60’s and reports to drink a couple of pints consistently every day.

Paul does not see anything wrong with his current level of drinking and has never received help/advice from services (health specific, alcohol specific or otherwise).

The main reasons given for drinking are that of sociability and cultural norms.

Interview 2: Brief synopsis

Mary is in her 90’s and talks about her experience in the War, and how this was the primary reason she began drinking.

Mary no longer drinks because of health reasons, but talks about the loss of her friend to alcohol.

Mary lives in sheltered accommodation and also talks about others, living there, who do drink regularly.

Help and services: age-appropriateness

Like responses from the quantitative questionnaires older adults, in the face-to-face interviews frequently commented on the age-appropriateness of alcohol services and how this may act as a barrier to engagement. This is clearly demonstrated in the quote: *"...if it was you advising me, I would listen to you, and take what you said on board, but the age appropriateness is definitely important to me. I don't think I would have opened up so much to you as I would have the counsellor"* [interview 4]. Age-appropriateness of service employees was also mentioned by Susan: *"Some kind of age similarity has got to be a working necessity"* [interview 3]. Thus responses from both the quantitative questionnaire and qualitative interviews supports the notion that alcohol services need to be age appropriate, with employees being a similar age to that of their clients. When this is the case, as it was for John, service effectiveness would appear to work very well: *"there is an essence that she has experienced a great deal as well and can relay that. Her assignment to me was appropriate"* [interview 4].

Effects of drinking: individual and family

Physical and health related consequences were the most commonly reported effects of drinking on the individual. For Paul, effects included level of tolerance and hangovers: *"there have been times when I have woken up in the morning and felt dreadful because of the drink"* [interview 1]. For Mary, alcohol led to myalgia: *"I was at a dinner party with my cousin and I got this awful pain in my bottom, my son diagnosed it later as alcohol induced myalgia"* [interview 2]. When discussing her late husband, Susan attributes his early death

as a consequence of prolonged drinking: *"he ended up dying from a combination of things but most brought on by alcohol; his moodiness became clinical depression"* [interview 3]. And for John: *"one doctor say that my white corpuscles were enlarged, which you will have if you booze"* [interview 4]. From these quotes it is clear to see that alcohol has had some physical and health effects for all individuals in question.

Alcohol was also shown to affect family members: *"drinking made him very moody and that made him very difficult to live with...he never inflicted his temper on our son but he could do quite scary things...I don't think I really knew quite how to cope"* [interview 3]. Thus, the effects of alcohol are not simply exclusive to the individual but can also impinge on the family.

Interview 3: Brief synopsis

Susan is in her late 70's and provides an overview of her experiences living with an alcoholic.

Her late husband passed away from what she suspects to be alcohol-related health implications.

Susan is adamant that alcohol is a hidden epidemic within the older population.

Interview 4: Brief synopsis

John is in his early 60's and has recently (in the last two years) sought help from Cardiff Alcohol and Drug Team.

John rates CADT very highly.

Loss of work and pain management is described as the primary reasons as to why alcohol use became problematic for John.

Results from Service Providers/Practitioners

Questionnaire data

In total, 38 service providers/practitioners completed the service provider/practitioner questionnaire. Of these, 12 were alcohol service providers, 8 were employees from non-alcohol-specific services and 18 worked in health care. On review, it was decided that combining the data, as one large data set, would be unjust based on the diverse experiences (with older problem drinkers) that go along with each occupation. That said, results (quantitative and qualitative) have been explored for each of the three strands of occupation (alcohol specific, non-alcohol-specific and health care) separately.

Results from: Alcohol Service Providers

Completed questionnaires were collected from alcohol service providers, including: Vale Alcohol and Drug Team(x4), Cardiff Alcohol and Drug Team(x2), Cardiff Addictions Unit(x2), Entry into Drug and Alcohol Service(x2) and The Integrated Family Support Service(x2).

Q1 – In your role, how often do you come into contact with older problem drinkers? (Rarely, Occasionally, Frequently or Everyday?)

- 9% (N=1) rarely come into contact with older problem drinkers;
- 75% (N=9) occasionally come into contact with older problem drinkers;
- 8% (N=1) have frequent contact with older problem drinkers;
- 8% (N=1) come into contact with older problem drinkers everyday.

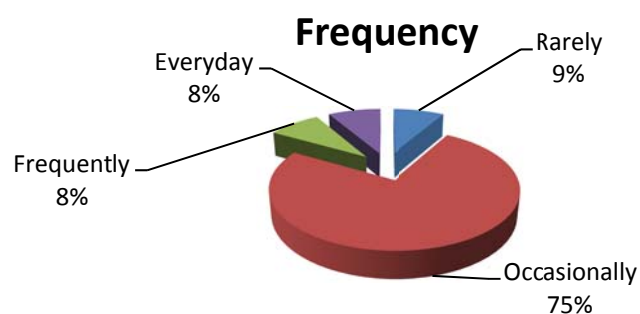


Figure 3: The frequency of which alcohol service providers come into contact with older problem drinkers

Q2 – Please state which kind of alcohol related physical injuries you see in older drinkers.

- 83% (n=10) reported seeing alcohol related falls;
- 50% (N=6) reported seeing alcohol related cuts;
- 75% (n=9) reported seeing alcohol related bruises;
- 42% (n=5) reported seeing alcohol related broken bones.

Q3 – Please state which kind of alcohol related health problems you see in older drinkers.

The top three reported health effects were:

- 100% (N=12) reported seeing alcohol related liver damage;
- 41% (N=5) reported seeing alcohol related insomnia;
- 75% (N=9) reported seeing alcohol related impaired cognitive functioning.

Q4 – Please state which kind of alcohol related mental health problems you see in older drinkers.

- 91% (N=11) reported seeing alcohol related anxiety;
- 100% (N=12) reported seeing alcohol related depression.

Q5 – Please state which kind or alcohol related drunken behaviour you see in older drinkers.

- 66% (N=8) reported seeing slurring of words;
- 50% (N=6) reported seeing balance problems;
- 41% (N= 5) reported seeing aggressive behaviour;
- 41% (N=5) reported seeing unconsciousness.

Q6 – Please state which kinds of alcohol related effects on day-to-day life you see in older drinkers.

- 83% (N=10) reported seeing loneliness;
- 58% (N=7) reported seeing self neglect;
- 50% (N=6) reported seeing poor hygiene.

Q7 – In your experience, are the drinking patterns of older people (60+) any different from the drinking patterns of other client groups you work with?

- 16% (N=2) of respondents felt that older people’s drinking habits were no different to younger people;
- However, the most common response (66%, N=8) was that older people are drinking *“alone, in their homes”*;
- Older adults more likely to drink *“wine or spirits rather than lager or cider”*;
- Older adults tend *“not to binge”* and view their drinking as a *“habit”* rather than a *“problem”*.

Q8 – In your experience, what are the main reasons why older people (60+) may drink?

Some of the key reasons given as to why older people may drink included that of:

- Isolation/Loneliness (58%);
- Continued Habit (58%);
- Perceived loss of social status/retirement (50%);
- Loss of a loved one (41%);
- Long term ill health and/or to help with sleep (41%).

Q9 – What kinds of services/interventions are you aware of locally that support older problem drinkers?

Most frequently listed services/interventions (by alcohol service providers) were:

- Age concern (33%);
- Cardiff Alcohol and Drug Team (33%);
- Cardiff Addictions Unit (25%);
- Recovery Cymru (25%);
- Pen Yr Enfys (16%);
- Living room (16%).

Q10 – How would you rate the services/interventions outlined above?

- 33% (N=4) of respondents feel that current services/interventions are *“good”*;
- However, 58% (N=7) commented on how these services are *“generic”* and *“not specifically older people focussed”*.

Q11/12 – What additional services/interventions and/or support would you like to see to support older adults with problem drinking?

- 50% (N=6) of respondents commented on how they would like to see *“specific services for older people”* and/or *“specific older people support groups”*;
- 33% (N=4) commented on how their needs to be more outreach/ease of access for this sample group, whether it be by means of a *“satellite clinic”* or *“home-visits”*.

Q13 – In your opinion, are professionals sufficiently aware of alcohol issues in older people?

Of the 10 completed responses:

- 20% said *“yes”*, professionals are sufficiently aware;
- 40% said *“no”*, professionals are not sufficiently aware
Example quotes: *“No I feel this client group can often be missed until they get admitted into hospital setting with an alcohol related problem”*;
- 40% said that *“some professionals are sufficiently aware, whilst others are not”*.

Results from: Other Service Providers (non-alcohol-specific)

Completed questionnaires were collected from employees working at non-alcohol-specific services, included: Age Connects (x3), Crossroads Care (x1), The Wallich (x1), Ty Ebril Care Home (x1), Taff Housing Association (x1) and Haven Homecare Trust (x1).

Q1 – In your role, how often do you come into contact with older problem drinkers? (Rarely, Occasionally, Frequently or Everyday?)

- 37% (N=3) rarely come into contact with older problem drinkers;
- 25% (N=2) occasionally come into contact with older problem drinkers;
- 25% (N=2) have frequent contact with older problem drinkers;
- 13% (N=1) come into contact with older problem drinkers everyday.

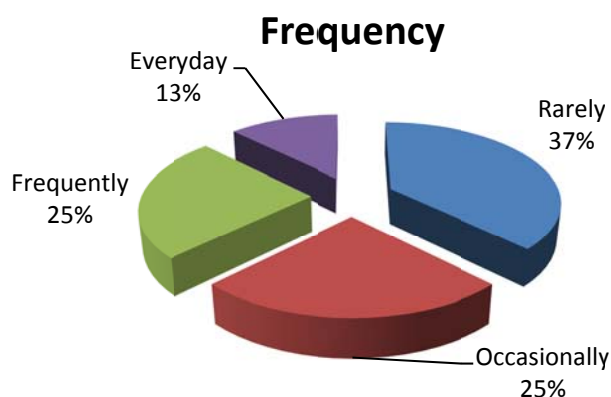


Figure 4: The frequency of which non-alcohol specific service providers come into contact with older problem drinkers

Q2 – Please state which kind of alcohol related physical injuries you see in older drinkers.

- 62.5% (N=5) reported seeing alcohol related falls;
- 25% (N=2) reported seeing alcohol related cuts;
- 50% (N=4) reported seeing alcohol related bruises;
- 37.5% (N=3) reported seeing alcohol related broken bones.

Q3 – Please state which kind of alcohol related health problems you see in older drinkers.

The top three reported health effects were:

- 62.5% (N=5) reported seeing alcohol related impaired cognitive functioning;
- 37.5% (N=3) reported seeing alcohol related liver problems;
- 37.5% (N=3) reported seeing alcohol related cancer.

Q4 – Please state which kind of alcohol related mental health problems you see in older drinkers.

- 50% (N=4) reported seeing alcohol related anxiety;
- 37.5% (N=3) reported seeing alcohol related depression.

Q5 – Please state which kind or alcohol related drunken behaviour you see in older drinkers.

- 50% (N=4) reported seeing slurring of words;
- 62.5% (N=5) reported seeing balance problems;
- 37.5% (N=3) reported seeing aggressive behaviour;
- 12.5% (N=1) reported seeing unconsciousness.

Q6 – Please state which kinds of alcohol related effects on day-to-day life you see in older drinkers.

- 75% (N=7) reported seeing self-neglect;
- 62.5% (N=5) reported seeing damaged family/friend relations;
- 62.5% (N=5) reported seeing poor hygiene.

Q7 – In your experience, are the drinking patterns of older people (60+) any different from the drinking patterns of other client groups you work with?

- One respondent (12.5%) felt that older people’s drinking habits were no different to younger people;
- However, the most common response (62.5%, N=5) was that older people are drinking “*more at home, in isolation*”.

Q8 – In your experience, what are the main reasons why older people (60+) may drink?

Some of the key reasons given as to why older people may drink included that of:

- Isolation/Loneliness (75%);
- Continued Habit (62.5%);
- Help with sleep (50%);
- Death of a loved one (50%);
- Perceived loss of social status (50%).

Q9 – What kinds of services/interventions are you aware of locally that support older problem drinkers?

Most frequently listed services (by non-alcohol-specific service providers) were:

- AA (25%);
- Cardiff Alcohol and Drug Team (12.5%);
- Cardiff Addictions Unit (12.5%);
- Recovery Cymru (12.5%);
- Newlink Wales (12.5%);

25% (N=2/8) of non-alcohol-specific service providers reported not knowing any services/interventions that locally support older problem drinkers.

Q10 – How would you rate the services/interventions outlined above?

- Only 2 out of 8 (25%) respondents commented on the effectiveness of local services and interventions - these responses were positively described as *“accessible”* and *“supportive”*;
- 5 out of 8 (62.5%) respondents did not comment (at all) on the effectiveness of local service and interventions;
- The remaining 1 respondent (12.5%) was *“unable to comment as do not know what services there are”*.

Q11/12 – What additional services/interventions and/or support would you like to see to support older adults with problem drinking?

- 50% (N=4) of respondents commented on how they would like to see *“more age appropriate services”*;
- 37.5% (N=3) commented on how there needs to be some type of *“specialist counselling service”* for older people;
- 35% (N=2) would like to see more *“ongoing support”* and activities to get *“older people involved in the community more”*.

Q13 – In your opinion, are professionals sufficiently aware of alcohol issues in older people?

Of the 5 completed responses:

- 20% (N=1) said *“yes”*, professionals are sufficiently aware;
- 40% (N=2) said *“no”*, professionals are not sufficiently aware
Example quote: *“In my opinion they are probably not but equally they are probably not sufficiently aware of the contributing factors that cause the problems”*;
- 40% (N=2) said that some professionals are sufficiently aware, whilst others are not
Example quote: *“Some professionals are aware but not a lot is in place to help people access the right support. Some professionals are not recognising the signs of older people drinking. There needs to be a more joined up co-ordinated approach to providing care/support for older people”*.

Results from: Health Care Providers

Completed questionnaires were collected from health care providers, including staff at: The University Hospital Wales (x14), Cardiff Alcohol Treatment Centre (x3) and Public Health Wales (x1).

Q1 – In your role, how often do you come into contact with older problem drinkers? (Rarely, Occasionally, Frequently or Everyday?)

- 0% (N=0) rarely come into contact with older problem drinkers;
- 22% (N=4) occasionally come into contact with older problem drinkers;
- 50% (N=9) have frequent contact with older problem drinkers;
- 28% (N=5) come into contact with older problem drinkers everyday.

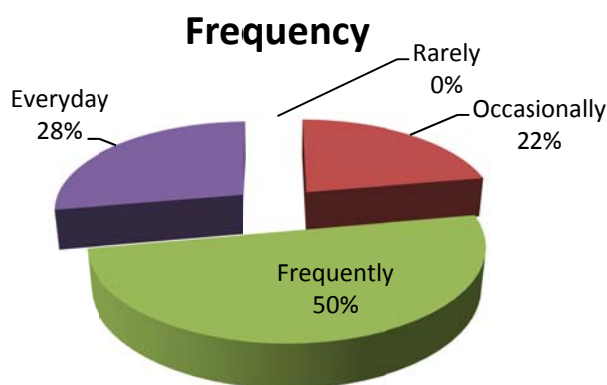


Figure 5: The frequency of which health care providers come into contact with older problem drinkers

Q2 – Please state which kind of alcohol related physical injuries you see in older drinkers.

- 94.4% (N=17) reported seeing alcohol related falls;
- 72.2% (N=13) reported seeing alcohol related cuts;
- 94.4% (N=17) reported seeing alcohol related bruises;
- 94.4% (N=17) reported seeing alcohol related broken bones.

Q3 – Please state which kind of alcohol related health problems you see in older drinkers.

- 88.8% (N=16) reported seeing alcohol related impaired cognitive functioning;
- 88.8% (N=16) reported seeing alcohol related liver damage;
- 66.6% (N=12) reported seeing alcohol related high/low blood pressure;
- 66.6% (N=12) reported seeing alcohol related heart problems.

Q4 – Please state which kind of alcohol related mental health problems you see in older drinkers.

- 72.2% (N=13) reported seeing alcohol related anxiety;
- 83.3% (N=15) reported seeing alcohol related depression.

Q5 – Please state which kind or alcohol related drunken behaviour you see in older drinkers.

- 88.8% (N=16) reported seeing slurring of words;
- 88.8% (N=16) reported seeing balance problems;
- 83.3% (N=15) reported seeing aggressive behaviour;
- 83.3% (N=15) reported seeing unconsciousness.

Q6 – Please state which kinds of alcohol related effects on day-to-day life you see in older drinkers.

- 94.4% (N=17) reported seeing self-neglect;
- 88.8% (N=16) reported seeing poor hygiene;
- 88.8% (N=16) reported seeing damaged family/friend relations.

Q7 – In your experience, are the drinking patterns of older people (60+) any different from the drinking patterns of other client groups you work with?

Of the health care providers who responded by questionnaire:

- 66.6% of respondents (N=12) reported that older people “*tend to have chronic alcohol problems*” in comparison to younger populations who “*binge drink*”;
- 66.6% of respondents (N=12) felt that older people drink “*more at home*”;
- 50% (N=9) feel that older people keep their drinking “*hidden*” from society.

Q8 – In your experience, what are the main reasons why older people (60+) may drink?

Some of the key reasons given as to why older people may drink included that of:

- Isolation/Loneliness (88.8%);
- Perceived loss of social status (77.7%);
- Continued habit (72.2%);
- Boredom (50%);
- A means of social companionship (44.4%).

Q9 – What kinds of services/interventions are you aware of locally that support older problem drinkers?

7 of the health care providers did not complete this section of the questionnaire. Of the 11 who did respond, listed services/interventions included:

- The Alcohol Liaison Nurse at the University Hospital Wales (33.3%);
- AA (16.6%);
- Age concern (11.1%);
- EDAS (5.5%);
- Inroads 1 (5.5%);

36.3% (N=4) of health care providers reported not knowing any age-specific services/interventions that locally support older problem drinkers.

Q10 – How would you rate the services/interventions outlined above?

Of the 10 health care providers who responded to this question:

- 22.2% (N=4) rated local services/interventions as “*excellent*” or “*good*”;
- However, the majority (N=6, 33.3%) commented on how services “*could be improved*” by means of making more age specific
Example quotes: “*services in Wales are VERY good, just not older people specific*”; “*current services can be intimidating for an older person in my opinion and not really sure how widely publicised the service is*”; “*Big service gap for this group*”.

Q11/12 – What additional services/interventions and/or support would you like to see to support older adults with problem drinking?

- 44.4% (N=8) of respondents commented on how they would like to see “*more age appropriate services*” for older problem drinkers;
- 33.3% (N=6) commented on how they would like to see more information directed towards older adults specifically, and/or more “*awareness raising in the public*”;
- 16.6% (N=3) suggested there needs to be “*more social groups or support groups for older people specifically*”.

Q13 – In your opinion, are professionals sufficiently aware of alcohol issues in older people?

Of the 15 completed responses to this question:

- 26.6% (N=4) said “*yes*”, professionals are sufficiently aware;
- 73.3% (N=11) said “*no*”, professionals are not sufficiently aware;
Example quote: “*No, needs more education all round*”.

Interview/Focus group data

Experiences and recommendations from: Alcohol Service Providers

6 focus groups were conducted with local alcohol service providers, including: Cardiff Alcohol and Drug Team (CADT), Entry into Drug and Alcohol Service (EDAS), Integrated Offender Intervention Service (IOIS), Newlands, The Living Room and Recovery Cymru.

For Cardiff Alcohol and Drug Team (CADT), the experience of older adults problem drinking was described as being similar to that of younger client groups: *"I would say that, if people find us, and get to us, they engage with us in the same way as any other group, and some of my most dedicated and committed clients have been in that age group..."*. However, the team felt that not all older adults with problem drinking are accessing the service: *"...but it's whether they find us and I don't think they are finding us"*.

Recommendations made by CADT were:

- The need to challenge ageist attitudes and myths that surround alcohol misuse.
- Employ positive public health messages which: *"emphasise strengths and build on people's quality of life issues"* as opposed to: *"emphasising problems"*.
- Some form of intervention available at GP surgeries: *"...whatever way you come at it, and even if that generation has mobility issues, they get to their GP...so that might be more of an opportune moment for them to have a look at that"*.
- Motivational interview training for all staff involved with older problem drinkers: *"And not just information training, not just you know telling people facts, but actually the confidence to work with them and cover those issues. Not everyone needs to come into a specialist service"*.

The team at Entry into Drug and Alcohol Service (EDAS) highlighted in their focus group, the disparity between number of referrals coming in (for older adults) and actual attendance rates: *"Referrals are high, particularly from {name removed} at UHW but they don't tend to come along...we might give them a ring and they say 'I don't have a problem, I'm not sure why they have referred me'...so the difference between the amount who are referred and those who actually attend it probably quite high"*. When probed further the EDAS team felt that older people were perhaps not attending because: *"...it's probably a lifetime culture really of drinking...there's a psychological resistance at that age...pride wise they want to keep it hidden."*

Recommendations by the EDAS team included:

- The need for a specialised service solely for older adults: *"...they know they are going to be going into a service and seeing a lot of younger people and that can be quite off-putting...or at least a service that would sit within an existing service"*.

- More accessible services for those with mobility/confidence issues: *“maybe little satellite services or something more accessible”*.
- Advice sessions targeted at older adults: *“...information focussed on older adults, you know to make them think they are not on their own and ‘oh yes, I am drinking too much”*”.

For the Integrated Offender Intervention Service (IOIS) team the experience of older people drinking is described as *“hidden”* and being the result of cultural norm: *“It’s a generation thing, a lot of the older drinkers are secret drinkers. It’s a shame they can’t admit it; I had a client who had all of her alcohol delivered to her so she didn’t even have to go shopping and get questioned about the crate of alcohol in her trolley; the older generation are drinking more at home and that’s why they are not coming through via our service so much”*. Recommendations made by the IOIS team included:

- Better pathways, better services and communication sharing.
- More information sharing about what services are available to refer into.

Newlands, like IOIS, feel that older people’s drinking is *“more hidden”* and is consequent to being *“part of their lifestyle”*. The team at Newlands also highlighted how older adults: *“don’t generally like to say ‘I have got a real problem with my drinking”*”. This type of lack of awareness or denial was further highlighted when the team discussed the motivational forces behind why they attend the alcohol service: *“the trend with the older adults is that it’s most certainly a family member who has brought them here, it’s not off their own admission, and generally when we get to see them in counselling there’s very little motivation to change because they almost feel like they are at that stage in their life where its ‘well why should I change”*”.

Recommendations made by Newlands team included:

- More specific screening/routine assessments when people are admitted to hospitals: *“...rather than just ‘how much do you drink?”*”
- More aftercare: *“The last person I worked with, the plan was to go from ADFER into local authority respite for 2 weeks, but they didn’t fit the criteria because they were self-catering, so they went straight back to their home, to the triggers that had been there all along, and started drinking again. So I think some sort of respite facility that catered for older people, to keep them away from those triggers”*.
- Age appropriate support centres: *“I don’t think older clients want to go to support centres with much younger people...there are few places that older people can go and socialise.”*
- Awareness raising on units and daily recommended limits: *“I honestly think that the majority of people still don’t count the units they are drinking, so whether there’s a different way, like explaining the size of your glass, I don’t know but something needs to be done.”*

For The Living Room team involved, all of whom were abstinent and in remission from alcohol misuse, the experiences of older people drinking were, again, described as being a *“hidden thing”*. The very personal accounts of having an alcohol problem that were expressed in this focus group highlighted just how injurious alcohol misuse can be: *“I fell down the stairs, broke my collar bone, cracked my head open, those kinds of things...we see physical stuff quite often here, whatever the age”*.

Recommendations from the Living Room team included:

- Better communication between health care practitioners: *“there’s a huge dilemma in the whole system of one group talking to another.”*
- Better communication between health boards.
- Awareness raising about local services that are available: *“all we are asking for is the help to put up the sign posts that we are here.”*
- Challenging assumptions that: *“you can’t recover from addiction”*. This can be done by: *“publishing recovery just as much as problem drinking is publicised”*.

For the Recovery Cymru team it was difficult to talk about their experiences with older problem drinkers as they are a relatively new organisation, *“still establishing themselves”*. Even so, the team commented on how they too felt it may be more of a hidden problem: *“I would probably guess that a lot of older people might be more hidden...”* and subsequent to this, they could: *“potentially be a group that we are not capturing yet”*. Recommendations from the Recovery Cymru team included:

- Having older support workers to: *“make it more easy for other older people to get involved, because you have to relate to certain people to feel comfortable”*; so the age-appropriateness of service providers (in this case being peer support groups).
- The need to have opportunities that make older people feel like they are *“still giving”* and *“being purposeful”*. One suggested way in which this could be done was to have success stories; so again, employing positive public health messages which emphasise strengths and build on people’s quality of life issues.

Experiences and recommendations from: Other Service Providers (non-alcohol-specific)

4 focus groups were conducted with other services (non-alcohol-specific) across Cardiff and the Vale, including: Cardiff Police, Diverse Cymru, Older Person’s Social Care Team and Newydd Housing Support.

Although the frequency of seeing older problem drinkers will be less for non-alcohol-specific services, staff at Cardiff Police were able to comment on cases in which they have seen problematic drinking in older adults. In these cases problem drinking was described as being a: *“chronic problem, which has persisted for many many years”*. For the police, the category

of alcohol and older people is deemed as *“one of the highest risk categories”*, particularly in terms of detaining people, because of *“the damage that the long term addiction has for them in terms of their health”*. Although the numbers of older adults, with problematic drinking, coming into custody are relatively small *“I can name them by hand”*, there is a high turnover in terms of these individuals coming to the attention of the police because *“the issues that cause concern persist for a very long time”*. This again supports the notion that drinking in older adults is usually a chronic problem.

- No specific recommendations were made by Cardiff Police.

As expected, being a non-alcohol-specific service, the frequency of having contact with older problem drinkers for Diverse Cymru employees was described as ‘rare’. That said however, Diverse Cymru employees were able to discuss a small amount of cases in which they feel their client(s) may have unidentified problematic drinking: *“I know of a case where he does drink on the side but there’s no definition there...it’s my personal opinion rather than him thinking he has a problem...it’s the little things that I would pick up on... like his shopping list will be full of cans”*. It is these example cases that support the notion of alcohol misuse being a hidden epidemic for older adults (as suggested earlier by Hanson & Gutheil, 2004). Recommendations made by Diverse Cymru included:

- The need for age-appropriate service providers: *“I have recruited and trained up quite a number of be-frienders but the clients don’t like them because they are too young...they want older be-frienders...they would rather have no service than having a younger person.”*
- Frank and honest public health announcements: *“pussyfooting is not going to work.”*
- Information targeted at slightly earlier generations (50 years +): *“I don’t want Welsh Government turning around saying ‘well if they don’t want it, no-body else is going to want it’...just because one generation doesn’t want that service, doesn’t mean that the next generation doesn’t need or want it.”*

Older Person’s Social Care Team talk openly about their experiences of working with older problem drinkers, describing just how injurious it can be at times: *“...she drank too much and fell asleep with a cigarette in her hand...set the flat on fire...and she spent 4 or 5 months in hospital for that; my service user is constantly in and out of hospital because of his alcohol dependency, so there’s a lot of wastage in that sense...when he was in the community it was like every other week that he would end up in the hospital”*. Recommendations made by the Older Person’s Social Care Team were:

- Better pathways and communication sharing: *“it’s a disjointed approach, it’s not working in partnership I don’t think, especially when there’s dual diagnosis.”*
- Age-specific services – or an arm within current services – for older problem drinkers: *“There needs to be more services available that would be helping the older generations.”*

Irrespective of place of residence, all Newydd Housing Support staff reported ‘occasionally’ seeing older residents with problematic drinking: *“I have a handful of tenants, two of which have identified alcohol addictions and others who I suspect drink; I’ve got one lady who has a serious alcohol issue...and then there’s another gentleman who drinks all day”*. Recommendations made by Newydd Housing Support staff included:

- More accessible services and/or home visits: *“I needed someone really who would come out and do a home visit, and that’s where it fell apart really, not being able to get them there.”*
- Better pathways and communication: *“It’s a very disjointed service, almost not connect at all. The separate parts are all right, but they don’t work together.”*
- Better communication between health care practitioners and services providers
- More aftercare: *“he needed someone to go in, on a daily basis, to give some kind of encouragement, but again, it just seemed that he would go in {for detox}, come back out, and it would be up to him to continue on his own...they need more support.”*
- Age-specific services – or an arm within current services - for older problem drinkers: *“I think it would be good to have something like an age concern alcohol service...”*

Experiences and recommendations from: Health Care Providers

Two interviews were conducted with health care providers working for: Public Health Wales (PHW) and the Elderly Mentally Ill (EMI) team.

From Public Health Wales’ perspective, current statistics on the amount of older people drinking are: *“massively under-reported”*. The main issue related to this is that: *“we are dealing with hidden or accepted drinking”*. What’s more, there is difficulty in acquiring accurate data because of what is described as: *“the dignity issue”*. In one example of this, it was found that a General Practitioner did not want to question an older gentleman’s drinking patterns because he too used to be a GP, and by questioning him about his drinking, the General Practitioner felt he would insult/undermine the gentleman: *“When we first started the programme what we did is we just targeted GP’s and one great anecdote that came out of that was ‘I know this old person who comes into my surgery every week is drinking too much, he’s got all the signs, all the symptoms, but I can’t say anything because he was my mentor...who am I, as this younger person, to question that’...and that to me, explains the problem”*.

Recommendations from Public Health Wales included:

- Age-specific services – are at least an arm within current services – for older problem drinkers: *“Dedicated services for older people absolutely.”*

- Trained service providers who are able to communicate with older people: *“in the right manner.”*
- Awareness raising on units and daily recommended limits: *“we need to address the messages around units and the systems of approaching that.”*

From the Elderly Mentally Ill (EMI) perspective, it is: *“very difficult to get the right service for”* older adults with dual diagnosis (alcohol problems and mental illness). What’s particularly difficult in these cases is that clients will either: *“forget to attend appointments”* or *“cannot retain the information”*. Recommendations based on this, were:

- Need for home-visits in cases where there is dual diagnosis (mentally ill and alcohol addiction).
- Need for more local specialist residential care: *“there is no specialist home for someone with alcohol dementia in this area...I think the nearest place is Devon...they have got different needs to people with just dementia...”*

Summary of focus group recommendations

From the focus groups, service providers/practitioners revealed that they would like to see:

Age-appropriate services

- ✚ Specialist service for older adults; stand alone or an arm within current services;
- ✚ Specialist support centres/satellite services for older adults;
- ✚ Age-appropriate service providers and/or support workers.

Better Communication and Pathways between current services

- ✚ More information about services available and how to refer into them;
- ✚ Better communication between health care practitioners and service providers;
- ✚ Better communication across health boards.

More screening, interventions and specialised after care

- ✚ Better screening/more routine assessments on admittance to hospital;
- ✚ Potential to have brief interventions placed within GP surgeries;
- ✚ Age-appropriate after care.

More training and professional development

- ✚ Motivational interviewing training for all staff who work with older problem drinkers.

Unambiguous public health messages

- ✚ Challenging ageist attitudes and myths that surround alcohol misuse;

- ✚ Highlighting strengths and building on people's quality of life issues (as opposed to emphasising problems);
- ✚ Awareness raising on units and daily recommended limits for older adults specifically;
- ✚ Awareness raising about local services that are available for older adults.

Evaluation of Outcomes

This research and scoping project aimed to collect data based on the following information:

- **Levels of harmful and problem drinking amongst those 60 years and over**

Findings: Of the 288 older adults who completed the questionnaire, 3.5% were shown to need referral to a specialist for diagnostic evaluation and treatment. This figure, when extrapolated to the population of older adults living in Cardiff and the Vale (95,493 at the time of data collection) suggests that there are approximately 3,342 older adults with hazardous and harmful patterns of alcohol consumption. In terms of gender, older males were shown to be significantly more likely to have hazardous and harmful patterns of alcohol consumption than older females. When AUDIT scores were broken down for each sub-domain, 17.7% of the sample group (approximately 16,902 when extrapolated) were shown to have hazardous alcohol use in terms of frequency, quantity and amount of heavy drinking.

Recommendation(s): These results reveal that older adults, living in Cardiff and the Vale, need advice/guidance based around recommended limits (frequency, quantity and the effects of heavy drinking).

- **Numbers accessing help from substance misuse services, and their views on how appropriate these services are for their needs**

Findings: Of the 288 older adults who completed the questionnaire, only 3 (1.03%) reported accessing substance misuse services. This is in comparison to the 3.8% who were found to need brief counselling and/or referral to a specialist for diagnostic evaluation and treatment. When this figure is generalised it can be concluded that there are a significant proportion of older adults, living in Cardiff and the Vale, whom should be accessing services but are not.

Recommendation(s): More research is definitively needed to explore alcohol misuse figures in terms of those being referred and the number of those accessing/not accessing services. Anecdotal figures from University Hospital Wales (UHW) suggested that 20-30% of general admissions, for adults 60 years and over, were alcohol related in some way (based on figures in February/March, 2014). Future research needs to consider how many of these patients are being referred, where they are being referred too, the number of patients

accessing the recommended service and the number of patients not accessing services. Only when this information is available will it be possible to say whether barriers to engagement are person-centred or subsequent to a lack of identification, referral and/or follow-up.

- **Numbers accessing other services where alcohol is an issue but no intervention has happened and why**

Findings: As mentioned above, only 3 participants in total (1.03%) reported accessing any type of service and in each case this was found to be a substance misuse service with interventions available. Thus, there were no identified cases in which older adults reported accessing other services where alcohol is an issue but no intervention has happened. Again, this highlights the degree to which older adults are not accessing any type of service.

Recommendation(s): As recommended above, more research is definitely needed to explore current estimates and whether barriers to engagement are person-centred or subsequent to a lack of identification, referral and/or follow-up.

- **What are the barriers to engagement for those not accessing services**

Findings: On an individual level, barriers to engagement included: feelings of shame and embarrassment, denial and/or a lack of understanding that their drinking is actually harmful/problematic. From an organisational perspective, the main barrier to engagement highlighted was that of current services not being age-appropriate for older adults.

Recommendation(s): This finding suggests that, in order to get older adults engaging with services, both person-centred approaches (addressing issues of shame, embarrassment, denial and/or a lack of understanding) and service-centred approaches (addressing issues of age-appropriateness) are needed.

- **Socio-economic status of older drinkers**

Findings: Socio-economic status was gauged, in this analysis, based on the participant's annual household income. Analysis of the 288 completed questionnaires revealed that alcohol misuse is more likely to occur within individuals with lower socio-economic status.

Recommendation(s): One of the limitations of the research design was that the majority of participants (75%) fell into the lower annual household income band, and thus there was not an equal spread of participants across all socio-economic (income) bands. Before a definitive conclusion can be drawn regarding socio-economic status of older drinkers, future research needs to have equally weighted sample groups across all socio-economic bands.

- **Current levels of harm/health problems related to alcohol**

Findings: The majority of health care practitioners reported frequently seeing alcohol-related falls (94.4%) and broken bones (94.4%) in older problem drinkers. Health care

practitioners also reported seeing detrimental health effects including alcohol related liver damage (88.8%) and impaired cognitive functioning (88.8%). Not only do these findings highlight the serious harm/health problems related to older drinkers, but the latter (with regards to impaired cognitive function), lends support to on-going research surrounding Alcohol-Related Brain Disorder (ARBD).

Recommendation(s): Harm/health problems related to alcohol misuse in older adults needs to be publicised with the anticipation of alcohol misuse prevention as opposed alcohol misuse treatment/intervention.

- **What training or awareness raising requirements do non specialist practitioners feel would help them recognise alcohol issues and what they could do to support individuals**

Findings: What was highlighted from this research is that non specialist practitioners are able to recognise alcohol issues in older adults, and are aware of at least some alcohol services in which they can refer into. That said however, non specialist practitioners frequently commented on how the referral process was lengthy and how specialist aftercare was almost non-existent. Thus, it is not so much to do with what training or awareness raising requirements non specialist practitioners need, but is much more to do with what can be done to current services and potential future services that will support their process in helping older problem drinkers.

Recommendation(s): Future service design and provision needs to consider how services (alcohol-specific and non-alcohol specific) can be modified to support older problem drinkers. From these findings, it can be recommended that the focus needs to be on current referral processes and specialist after-care; as opposed to awareness raising for non specialist practitioners.

- **What service providers/practitioners feel is needed**

Findings: A number of recommendations were made by service providers/practitioners with regards to what they feel is needed for older problem drinkers. Recommendations included: having new age-appropriate services or at least an arm within current services, better communication and pathways between current services, more screening, interventions and specialised after care, more training and professional development and unambiguous public health messages.

Recommendation(s): Cardiff and the Vale Substance Misuse Area Planning Board need to consider the recommendations from local service providers/practitioners above, and consider all suggestions for future policy context and service design.

- **How best to ensure older people and their families get accurate, accessible information about alcohol use**

Findings: The main recommendation with regards to how best ensure that older people and their families get information about alcohol use was that of employing positive public health messages which raise awareness about safe limits and services available for older adults. Other recommendations included having age-appropriate support centres/advice sessions and more information/advice given at GP surgeries.

Recommendation(s): Public health messages need to raise awareness around units and safe limits for older adults specifically. Advice centres need to be accessible, and more information specific to older adults is needed ubiquitously. This information should include: harm/health problems related to alcohol and local services available to them.

Project strengths and limitations

One of the limitations with regards to the design of the research was the lack of definition as to what constitutes 'one' drink. On reflection, some participants may regard half a glass of shandy as constituting 'one' drink, whereas another individual may feel that a bottle of cider constitutes 'one' drink. In the latter case, the individual would be underestimating how much they drink and would be drinking a significant amount more than the first individual (even though they both put the same amount of 'one drink'). Future research needs to bear this in mind and be more explicit when asking older adults to define how much they drink. Even with this limitation however, the results cannot possibly get any 'better' than they already are; even if all participants had underestimated their drinking (e.g. one bottle of cider constituting 'one drink') the true results could only reflect more of a problem than has already been highlighted. Thus, this research highlights a significant - but potentially underestimated - problem of alcohol misuse in older adults.

Another project limitation was the lack of equally weighted sample groups across all socio-economic (income) bands; the majority of participants (75%) had the lowest income band of £0-£25,000. Before a definitive conclusion can be drawn between socio-economic status of older drinkers, future research needs to have an equal spread of participants across all socio-economic bands. Future research also needs to have more of an equal spread of participants across postcode regions as well as a more equal ratio of male to female participants. To counterbalance this however, with Peter Wiltshire Farmfoods randomly distributing 1,000 copies of the older adults' questionnaire into people's homes, the ecological validity of the results is very strong. In no case was data collection biased to a specific 'type of individual', and thus the results can be generalised to the population of older adults living in Cardiff and the Vale at the time of data collection.

Not only are the results high in ecological validity but they offer an uncharted insight into alcohol misuse in older adults specific to Cardiff and the Vale. The results offer current estimates which were previously unknown and an invaluable insight into the experiences/opinions of local service providers and health care practitioners. With the majority of previous substance misuse research being that of American or Australian by nature (demonstrated in the literature review) this research highlights the need for more UK based research and offers a strong starting point for future investigations.

This research also adds to the literature by highlighting the importance of analysing sub-domain AUDIT scores as well as individual question analysis. Had only the overall AUDIT scores been considered (the case in most previous research) the significant findings of participants drinking more than daily recommended limits (25.9%) and numbers with hazardous alcohol use (17.7%) would not have been identified. Thus, it is strongly recommended that future research and practice considers the strength of analysing sub-domain scores (which comprise the overall AUDIT score) and individual question analysis.

Recommendations

- ✚ Older adults require advice and/or guidance based around recommended limits (frequency, quantity and the effects of heavy drinking).
- ✚ More information needed specific to older adults including: information on units, harm/health effects related to drinking and current services available.
- ✚ More UK based research needed including research exploring alcohol misuse figures in terms of those being identified/referred to substance misuse services and the number of individuals accessing/not accessing services (and why).
- ✚ Both person-centred (addressing issues of shame, denial and/or a lack of understanding) and service-centred (addressing issues of age-appropriateness) approaches need to be considered when dealing with barriers to engagement.
- ✚ Current levels of harm/health problems related to alcohol need to be publicised with the aim of alcohol misuse prevention as opposed to alcohol misuse treatment.
- ✚ Commissioners and strategic planners need to consider whether new services are required to meet the needs of older adults or whether existing services can be modified to meet their needs.
- ✚ Suggestions from service providers and practitioners need to be considered in future commissioning and planning, including the requirements for:
 - Age-appropriate services, or at least an arm within current services, for older adults;
 - Support centres and/or advice sessions specific to older adults;
 - Satellite services or outreach programmes for older adults with mobility issues;
 - Better communication between current services;
 - More screening, interventions and specialist after-care for older adults;
 - More training and professional development around older problem drinkers;
 - Unambiguous yet positive public health messages.
- ✚ Future administrators of the Alcohol Use Disorders Identification Test (AUDIT) should consider the strengths (highlighted in this report) of examining sub-domain scores independently from one another and/or separate individual question analysis.

Conclusion

In conclusion, this research may act as a stepping stone towards understanding the impact of alcohol on older people across Cardiff and the Vale. Current estimates of harmful and problem drinking are now known and recommendations from service providers and practitioners are made with regards to the support of older problem drinkers. With the main recommendation being that of having age-appropriate services, or at least an arm within current services, future research is needed to explore whether such a service would be viable and beneficial for older problem drinkers. Future research is needed to explore barriers to engagement, particularly those based around shame and embarrassment and to explore whether age-specific services would help address these issues. Communication between services (alcohol-specific, non-alcohol-specific and health care) is highlighted as being very disjointed and future research needs to explore whether it is these shortcomings in communication that act as a further barrier to engagement. To sum up, we now know more regarding the impact of alcohol on older people across Cardiff and the Vale but there is still a lot to be learnt through further research.

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Appendices

Appendix 1 – Questionnaire for Older Adults

Appendix 2 – Interview Schedule for Older Adult interviews/focus groups

Appendix 3 – Questionnaire for Service Providers/Practitioners

Appendix 4 – Interview schedule for Service Provider/Practitioner interviews/focus groups

Appendix 5 – SPSS output data

Appendix 6 - Most frequently reported alcoholic drinks consumed by older adults

Appendix 7 – AUDIT questions and optional answers

Appendix 8 – Postcode breakdown

Appendix 1

Your views on alcohol

Questionnaire for older adults

The Local Health Board has commissioned research into the impact of alcohol on older adults across Cardiff and the Vale of Glamorgan. The aim of this questionnaire is to establish current levels of drinking amongst those 60 years and over. By completing the questionnaire you will be helping towards essential data collection, which will ultimately act as the basis for recommendations back to both the Local Health Board and current services.

All answers you supply will remain anonymous, and your results will be treated confidentially at all times. If you are happy to participate, please attempt to answer all questions; however, do not feel obligated to answer anything that makes you feel uncomfortable.

If you are happy to participate, please could you complete the questionnaire as soon as possible and return to hayley.bartlett@thewallich.net, or send to:

Miss Hayley Bartlett

The Wallich Centre,

Cathedral Road,

Cardiff,

CF11 9JF.

If you require further information, please do not hesitate to contact the research team at: hayley.bartlett@thewallich.net

1. What is your age?

2. What is your gender?

- Male
- Female

3. What is the first half of your postcode?

4. Which of these best describes your annual household income?

- £0 - £24,999
- £25,000 - £49,999
- £50,000 - £99,999
- £100,000 - £149,999
- £150,000 +

5. How often do you have a drink containing alcohol?

- Never
- Monthly or less
- 2 to 4 times a month
- 2 to 3 times a week
- 4 or more times a week

6. How many drinks containing alcohol do you have on a typical day when you are drinking?

- 1 or 2
- 3 or 4
- 5 or 6
- 7 to 9
- 10 or more

7. How often do you have 5 or more drinks on one occasion?

- Never
- Less than Monthly
- Monthly
- Weekly
- Daily or almost daily

8. How often during the last year have you found that you were not able to stop drinking once you had started?

- Never
- Less than monthly
- Monthly
- Weekly
- Daily or almost daily

9. How often during the last year have you failed to do what was normally expected of you because of drinking?

- Never
- Less than monthly
- Monthly
- Weekly
- Daily or almost daily

10. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?

- Never
- Less than monthly
- Monthly
- Weekly
- Daily or almost daily

11. How often during the last year have you had a feeling of guilt or remorse after drinking?

- Never
- Less than monthly
- Monthly
- Weekly
- Daily or almost daily

12. How often during the last year have you been unable to remember what happened the night before because of your drinking?

- Never
- Less than monthly
- Monthly
- Weekly
- Daily or almost daily

13. Have you or someone else been injured because of your drinking?

- No
- Yes, but not in the last year
- Yes, during the last year

14. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?

- No
- Yes, but not in the last year
- Yes, during the last year

15. From the list below, please select which drinks you drink (if any):

- | | | |
|--|--------------------------------------|-----------------------------------|
| <input type="checkbox"/> Wine (white, red or rose) | <input type="checkbox"/> Cider | <input type="checkbox"/> Whisky |
| <input type="checkbox"/> Champagne | <input type="checkbox"/> White cider | <input type="checkbox"/> Tequila |
| <input type="checkbox"/> Ale | <input type="checkbox"/> Gin | <input type="checkbox"/> Brandy |
| <input type="checkbox"/> Lager | <input type="checkbox"/> Vodka | <input type="checkbox"/> Liqueurs |
| <input type="checkbox"/> Beer | <input type="checkbox"/> Rum | <input type="checkbox"/> Other |

Other (please specify)

16. Do you personally feel that you need help for your current level of drinking?

Yes

No

(Please note: Details of a free and bilingual alcohol and drugs helpline are provided at the end for anybody wishing to seek further information and/or help).

17. Do you receive any help for your current level of drinking?

Yes

No

18. If you answered yes to question 17, please provide some information about the help/service you receive (e.g. which service it is and your thoughts about its effectiveness, accessibility etc):

19. In your opinion, are there any reasons as to why some older adults (with problem drinking), may not seek help/access services?

20. If you want to add ANY further comments, please do so in the box provided:

That concludes the questionnaire. Thank you very much for your participation. If you would like any more information about this research please contact the research team at: hayley.bartlett@thewallich.net or call 07824991457.

As part of this project we would also like to interview people about their general experiences of drinking. If you are able and willing to help with this, please provide some sort of contact information in the box below; the research team will then contact you to arrange this.

Please note, any contact information you provide will remain strictly confidential.

For further information and/or help with regards to drinking:

If you are **concerned** about your own **drinking**, or **worried** about a family member or friend, please contact Dan 24/7; a free and bilingual telephone helpline providing a single point of contact for anyone in Wales wanting further information and/or help relating to alcohol and drugs. The helpline will assist individuals, their families, carers, and support workers within the alcohol and drug field to access appropriate local and regional services. The service is available 24 hours a day, 7 days a week.

Freephone: 0808 808 2234

Or text DAN to: 81066

See more at: <http://dan247.org.uk/#sthash.UDqQSTso.dpuf>



Appendix 2

Your views on drinking

Interview/focus group materials for older adults

Pre interview/focus group briefing:

- Introduction; who we are, where we are from.
- Introduction to the project; Based on recommendations made by Alcohol Concern. Supported and commissioned by the Local Health Board. Aims to explore the impact of alcohol on older people across Cardiff and the Vale of Glamorgan specifically.
- Outcomes of the project; report produced for the Local Health Board which will provide a picture of levels of harmful and problem drinking amongst those over 60, numbers currently using services, efficiency of current services, what current service providers/practitioners feel is needed and barriers to engagement. From the findings recommendations will be made regarding what training/awareness raising is needed (if any), and whether specific age related services are required.
- Use of data; all information provided from older adults will remain completely anonymous and confidential at all times. Once transcribed, we will send the transcript back to the participant to allow them to check, correct and comment on anything from the interview.
- Ethics; Participant is not obliged to answer anything they feel uncomfortable in doing so. They have the right to stop the interview/focus group at any given time, and can withdraw any information they may have already provided (if they so wish).
- Ask if participant has any questions.

General interview/focus group questions:

<u>General question</u>	<u>Follow up probe(s)</u>
<u>Theme 1: Drinking lifestyle</u>	
Tell me a bit about you and alcohol: Do you drink?	If yes, what do you drink and how often?
Has this always been the case: when did you first start drinking?	Has the level of drinking remained the same or changed over time (gone up, gone down)?
What is your general experience with alcohol?	Bad thing? Good thing?
Is your current level of drinking something you are happy with, or would you like it to change?	Why? Why now?

Theme 2: Reasons for drinking	
Why do you drink?	Retirement, Death of a loved one, Long term ill-health, Sleep disruption, An increase in social isolation, social companionship (if they drink socially), Negative feelings about a perceived loss of social status, Impaired function abilities, Reduced coping skills, Pain management; other?
Theme 3: Help & Services	
Does your level of drinking worry you?	For yes or no: Why?
Do you feel you need help for your current level of drinking?	Has anyone (friends, relatives, healthcare professionals) recommended you get help?
Do you receive any help with your current level of drinking?	Services? GP? Etc. If yes, what are their general perceptions of the help/service provided; Effective? Accessible? If No, what are the barriers to engagement?
Theme 4: Effects of drinking	
Has drinking affected your health physically in any way?	Problems of the digestive system, liver and kidneys? Incontinence? Hypothermia? ARBD? Effects with prescription medications?
Has drinking affected your day-to-day life in any way?	Difficulties with sleeping? Poor balance and falls? Not looking after yourself (eating/cleaning etc)? Do you get hangovers? Has drinking stopped you from attending/doing something?
Has drinking affected you psychologically in any way?	Confusion and problems with memory?
Has drinking affected you emotionally in any way?	Anxiety and depression?

Post Interview Debriefing:

- Thank interview participant and ask if they have any questions; check if happy for us to proceed to transcription, ask if they want to review their interview (listen again) and confirm that we will submit the transcript for checking. Confirm what will be happening with the data and ask for feedback on the interview. Provide help details (Dan 24/7) if necessary.

Appendix 3

Understanding and improving services/interventions for older problem drinkers

Questionnaire for Service Providers and Practitioners

Alcohol use disorders in older people are a common but under recognised problem associated with major physical and psychological health problems. After recommendations made by Alcohol Concern, the Local Health Board has commissioned a report exploring the impact of alcohol on older people across Cardiff and the Vale of Glamorgan specifically. This project seeks to highlight current levels of harmful and problem drinking amongst those 60 years and over, confirm what kind of numbers are currently using services, and explore what service providers/practitioners feel is needed; thus looking at possible ways of meeting the alcohol related needs of older people.

As part of this work it would be really helpful if you could complete the following questionnaire. By completing the questionnaire you give consent to participate. Please could you complete the questionnaire as soon as possible and return to Hayley.bartlett@thewallich.net, or post to Hayley Bartlett, The Wallich Centre, Cathedral Road, Cardiff, CF11 9JF.

If you have any questions, or require further information, please contact the research team at: Hayley.bartlett@thewallich.net

Name:

Job title:

Organisation:

Client group:

Age of client group you specialise in:

1.) In your role, how often do you come into contact with older problem drinkers (those aged 60+)?

- Rarely
- Occasionally
- Frequently
- Everyday

2) Please tick which kind of alcohol related injuries, illnesses and behaviours you see from the lists below:

Physical injuries

- | | |
|--------------------------------|---------------------------------------|
| <input type="checkbox"/> Falls | <input type="checkbox"/> Broken bones |
| <input type="checkbox"/> Cuts | <input type="checkbox"/> Bruises |

Other (please specify)

Health problems

- | | |
|---|---|
| <input type="checkbox"/> High or low blood pressure | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Heart problems | <input type="checkbox"/> Insomnia |
| <input type="checkbox"/> Liver problems | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Kidney problems | <input type="checkbox"/> Impaired cognitive functioning |

Other (please specify)

Mental health problems

- | | |
|----------------------------------|-------------------------------------|
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Depression |
|----------------------------------|-------------------------------------|

Other (please specify)

Drunken behaviour

- Slurring of words
- Balance problems
- Aggressive behaviour
- Unconsciousness

Other (please specify)

Day-to-day effects

- Self neglect
- Loneliness
- Finance problems
- Damaged family/friend relations
- Poor hygiene
- Improved sociability
- Sleep disturbances

Other (please specify)

2.) In your experience, are the drinking patterns of older people (60+) any different from the drinking patterns of other client groups you work with? If yes, please can you explain how they are different (e.g. amount they drink, how often they drink, where they drink etc.)

3.) In your experience, what are the main reasons why older people (60+) may drink more than the recommended daily limits?

- | | | |
|---|--|--|
| <input type="checkbox"/> Continued habit | <input type="checkbox"/> Boredom | <input type="checkbox"/> Social isolation |
| <input type="checkbox"/> Pain management | <input type="checkbox"/> Death of a loved one | <input type="checkbox"/> Perceived loss of social status |
| <input type="checkbox"/> Retirement | <input type="checkbox"/> Long term ill health | <input type="checkbox"/> Impaired function abilities |
| <input type="checkbox"/> Help with sleeping | <input type="checkbox"/> A means of social companionship | |

Other (please specify)

4.) What kinds of services/interventions are you aware of **locally** that support older problem drinkers (for those that are 60+)?

5.) How would you rate the services/interventions outlined in question 5?

6.) What additional/alternative services/interventions do you feel are needed to help older adults with problem drinking (for those that are 60+)?

7.) Other than services/interventions, what further support would you like to see to support older people with problem drinking?

8.) In your opinion, are professionals sufficiently aware of alcohol issues in older people?

That concludes the questionnaire. Thank you very much for your participation. If you would like any more information about this research please contact the research team at: hayley.bartlett@thewallich.net

If you would like to add any further comments or suggestions, please feel free to do so in the following box:

Appendix 4

Understanding and improving services/interventions for older problem drinkers

Interview/focus group materials for service providers and practitioners

Pre interview/focus group briefing:

- Introduction; who we are, where we are from.
- Introduction to the project; Based on recommendations made by Alcohol Concern. Supported and commissioned by the Local Health Board. Aims to explore the impact of alcohol on older people across Cardiff and the Vale of Glamorgan specifically.
- Outcomes of the project; report produced for the Local Health Board which will provide a picture of levels of harmful and problem drinking amongst those over 60, numbers currently using services, efficiency of current services, what current service providers/practitioners feel is needed and barriers to engagement. From the findings recommendations will be made regarding what training/awareness raising is needed (if any), and whether specific age related services are required.
- Use of data; all information provided will be confidential where possible. There may be some exceptions (e.g. if we wish to highlight a “case study” example of good service provision/intervention then we may need to say which service provider this comes from), but individual participants’ responses will not be identifiable as coming from them in the report. Once transcribed, we will send the transcript back to participant to allow them to check, correct and comment on anything from the interview (if they so wish).
- Ethics; Participant is not obliged to answer anything they feel uncomfortable in doing so. They have the right to stop the interview/focus group at any given time, and can withdraw any information they may have already provided (if they so wish).
- Ask if participant has any questions.

General interview/focus group questions:

<u>General question</u>	<u>Follow up probe(s)</u>
Theme 1: General experiences of problem drinking in older adults <hr/>	
In your role, how often do you come into contact with older problem drinkers?	Rarely, occasionally, frequently, everyday?

Approximately what percentage of your current client group has identified problem drinking?	Changes in prevalence over time? (Gone up/gone down, or remained about the same?)
What are your general experiences with this client group (older problem drinkers?)	Good/Bad? Any different from other client groups? If they are different: how? (what they drink, frequency, amount etc)
In your experience, what are the reasons why older people problem drink?	Retirement, death of a loved one, long term ill health, sleep disruption, an increase in social isolation, significant changes causing disorder in way of life, negative feelings about a perceived loss of social status, impaired functioning, reduced coping skills, pain management; or other?
Theme 2: Impact of problem drinking	
Do you see alcohol related Physical injuries?	Falls, broken bones, bruises, cuts; or other?
Do you see alcohol related health problems?	High or low blood pressure, heart problems, liver and kidney problems, stroke, cancer, insomnia, ARBD (cognitive functioning); other?
Do you see alcohol related mental health problems?	Depression, anxiety; or other?
Do you see alcohol related drunken behaviour?	Slurring of words, poor balance, aggressive behaviour, unconsciousness; or other?
Do you see alcohol related self neglect/poor hygiene?	Incontinence, poor cleanliness; or other?
Effects on day-to-day life?	Finances, family/friend relations, sleep patterns, loneliness, improved sociability; other?
Theme 3: Assessment, screening and interventions	
How do you assess/screen for problem drinking in older adults?	Screening tools used; standardised – actuarial/clinical? Who is involved and in what capacity; decision-making process?
What interventions (if any) do you provide for older adults with identified drinking problems?	Specific interventions: what do these involve? Are they referred on to someone else?
How do older problem drinkers respond to the service/interventions you provide?	Good/bad? Better/worse than other client groups? Different to any other client group; how?
Do you think problem drinking in older adults ever goes undetected?	If yes, why might this be? Different factors which mask the problem?
Theme 4: Awareness of local services/interventions	

What kinds of services/interventions are you aware of locally that support older problem drinkers?	How would you rate these: perceptions of service availability, ease of access, balance of in-house vs. external services?
What additional/alternative services/interventions do you feel are needed to help older adults with problem drinking?	Explain/give reasons for response.
Theme 5: Training and professional development	
Please can you describe the training you/members of your team have received in this area?	Perceptions of the efficacy of the training, how well does this work for assessment/intervention of problem drinking in older adults?
Please describe any ongoing mentoring/training you receive to support your work with older adults that have drinking problems.	Examples: Involvement of external organisations in mentoring/training, access to professional forum/support networks?
Are there any areas where you feel you need further training/mentoring?	Explain/give reasons for response.
In your opinion, are professionals sufficiently aware of alcohol problems in older adults?	Explain/give reasons for response.
Theme 6: General perceptions	
What further support would you like to see to support older people with problem drinking?	Explain/give reasons for response.
Is there anything else you would like to say about your work with older problem drinkers?	

Post Interview Debriefing:

- Thank interview participant and ask if they have any questions; check if happy for us to proceed to transcription, ask if they want to review their interview (listen again) and confirm that we will submit the transcript for checking. Confirm what will be happening with the data and ask for feedback on the interview.

Appendix 5

SPSS output data

AUDIT scores overall:

AUDIT (scores overall)

	Frequency	Percent	Valid Percent	Cumulative Percent
Alcohol education	253	87.8	87.8	87.8
Simple advice	24	8.3	8.3	96.2
Simple advice and brief counselling and continued monitoring	1	.3	.3	96.5
Referral to specialist for diagnostic evaluation and treatment	10	3.5	3.5	100.0
Total	288	100.0	100.0	

Split file – gender and overall AUDIT score

AUDIT Overall (split file)

Gender		Frequency	Percent	Valid Percent	Cumulative Percent
Male	Alcohol education	63	77.8	77.8	77.8
	Simple advice	12	14.8	14.8	92.6
	Referral to specialist	6	7.4	7.4	100.0
Female	Alcohol education	190	91.8	91.8	91.8
	Simple advice	12	5.8	5.8	97.6
	Simple advice and brief counselling and continued monitoring	1	.5	.5	98.1
	Referral to specialist	4	1.9	1.9	100.0

AUDIT 1 Q) How often do you have a drink containing alcohol?

AUDIT 1 (overall scores)

	Frequency	Percent	Valid Percent	Cumulative Percent
Never	43	14.9	14.9	14.9
Monthly or less	75	26.0	26.0	41.0
Valid 2-4 times a month	59	20.5	20.5	61.5
2-3 times a week	51	17.7	17.7	79.2
4 or more times a week	60	20.8	20.8	100.0
Total	288	100.0	100.0	

Split file – gender and AUDIT 1

AUDIT 1 (split file)

Gender		Frequency	Percent	Valid Percent	Cumulative Percent
Male	Never	10	12.3	12.3	12.3
	Monthly or less	11	13.6	13.6	25.9
	2-4 times a month	10	12.3	12.3	38.3
	2-3 times a week	25	30.9	30.9	69.1
	4 or more times a week	25	30.9	30.9	100.0
	Total	81	100.0	100.0	
Female	Never	33	15.9	15.9	15.9
	Monthly or less	64	30.9	30.9	46.9
	2-4 times a month	49	23.7	23.7	70.5
	2-3 times a week	26	12.6	12.6	83.1
	4 or more times a week	35	16.9	16.9	100.0
	Total	207	100.0	100.0	

AUDIT 2 Q) How many drinks containing alcohol do you have on a typical day when you are drinking?

AUDIT 2 (overall scores)

	Frequency	Percent	Valid Percent	Cumulative Percent
1 or 2	214	74.3	74.3	74.3
3 or 4	52	18.1	18.1	92.4
5 or 6	15	5.2	5.2	97.6
7 to 9	2	.7	.7	98.3
10 or more	5	1.7	1.7	100.0
Total	288	100.0	100.0	

Split file – gender and AUDIT 2

AUDIT 2 (split file)

Gender		Frequency	Percent	Valid Percent	Cumulative Percent
Male	1 or 2	56	69.1	69.1	69.1
	3 or 4	14	17.3	17.3	86.4
	5 or 6	7	8.6	8.6	95.1
	10 or more	4	4.9	4.9	100.0
	Total	81	100.0	100.0	
Female	1 or 2	158	76.3	76.3	76.3
	3 or 4	38	18.4	18.4	94.7
	5 or 6	8	3.9	3.9	98.6
	7 to 9	2	1.0	1.0	99.5
	10 or more	1	.5	.5	100.0
	Total	207	100.0	100.0	

AUDIT 3 Q) How often do you have 5 or more drinks on one occasion?

AUDIT 3 (overall scores)

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Never	224	77.8	77.8	77.8
	Less than monthly	25	8.7	8.7	86.5
	Monthly	15	5.2	5.2	91.7
	Weekly	14	4.9	4.9	96.5
	Daily or almost daily	10	3.5	3.5	100.0
	Total	288	100.0	100.0	

Split file – gender and AUDIT 3

AUDIT 3 (split file)

Gender		Frequency	Percent	Valid Percent	Cumulative Percent
Male	Never	50	61.7	61.7	61.7
	Less than monthly	12	14.8	14.8	76.5
	Monthly	5	6.2	6.2	82.7
	Weekly	8	9.9	9.9	92.6
	Daily or almost daily	6	7.4	7.4	100.0
	Total	81	100.0	100.0	
Female	Never	174	84.1	84.1	84.1
	Less than monthly	13	6.3	6.3	90.3
	Monthly	10	4.8	4.8	95.2
	Weekly	6	2.9	2.9	98.1
	Daily or almost daily	4	1.9	1.9	100.0
	Total	207	100.0	100.0	

AUDIT 4 Q) How often during the last year have you found that you were not able to stop drinking once you had started?

AUDIT 4 (overall scores)

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid Never	261	90.6	90.6	90.6
Less than monthly	14	4.9	4.9	95.5
Monthly	2	.7	.7	96.2
Weekly	2	.7	.7	96.9
Daily or almost daily	9	3.1	3.1	100.0
Total	288	100.0	100.0	

Split file – gender and AUDIT 4

AUDIT 4 (split file)

Gender		Frequency	Percent	Valid Percent	Cumulative Percent
Male	Never	70	86.4	86.4	86.4
	Less than monthly	6	7.4	7.4	93.8
	Monthly	1	1.2	1.2	95.1
	Daily or almost daily	4	4.9	4.9	100.0
	Total	81	100.0	100.0	
Female	Never	191	92.3	92.3	92.3
	Less than monthly	8	3.9	3.9	96.1
	Monthly	1	.5	.5	96.6
	Weekly	2	1.0	1.0	97.6
	Daily or almost daily	5	2.4	2.4	100.0
	Total	207	100.0	100.0	

AUDIT 5 Q) How often during the last year have you failed to do what was normally expected of you because of drinking?

AUDIT 5 (overall scores)

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid Never	267	92.7	92.7	92.7
Less than monthly	13	4.5	4.5	97.2
Monthly	2	.7	.7	97.9
Weekly	2	.7	.7	98.6
Daily or almost daily	4	1.4	1.4	100.0
Total	288	100.0	100.0	

Split file – gender and AUDIT 5

AUDIT 5 (split file)

Gender		Frequency	Percent	Valid Percent	Cumulative Percent
Male	Never	69	85.2	85.2	85.2
	Less than monthly	7	8.6	8.6	93.8
	Monthly	1	1.2	1.2	95.1
	Daily or almost daily	4	4.9	4.9	100.0
	Total	81	100.0	100.0	
Female	Never	198	95.7	95.7	95.7
	Less than monthly	6	2.9	2.9	98.6
	Monthly	1	.5	.5	99.0
	Weekly	2	1.0	1.0	100.0
	Total	207	100.0	100.0	

AUDIT 6 Q) How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?

AUDIT 6 (overall scores)

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid Never	278	96.5	96.5	96.5
Less than monthly	4	1.4	1.4	97.9
Monthly	2	.7	.7	98.6
Weekly	1	.3	.3	99.0
Daily or almost daily	3	1.0	1.0	100.0
Total	288	100.0	100.0	

Split file – gender and AUDIT 6

AUDIT 6 (split file)

Gender		Frequency	Percent	Valid Percent	Cumulative Percent
Male	Never	75	92.6	92.6	92.6
	Less than monthly	1	1.2	1.2	93.8
	Monthly	1	1.2	1.2	95.1
	Weekly	1	1.2	1.2	96.3
	Daily or almost daily	3	3.7	3.7	100.0
	Total	81	100.0	100.0	
Female	Never	203	98.1	98.1	98.1
	Less than monthly	3	1.4	1.4	99.5
	Monthly	1	.5	.5	100.0
	Total	207	100.0	100.0	

AUDIT 7 Q) How often during the last year have you had a feeling of guilt or remorse after drinking?

AUDIT 7 (overall scores)

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid Never	263	91.3	91.3	91.3
Less than monthly	13	4.5	4.5	95.8
Monthly	3	1.0	1.0	96.9
Weekly	3	1.0	1.0	97.9
Daily or almost daily	6	2.1	2.1	100.0
Total	288	100.0	100.0	

Split file – gender and AUDIT 7

AUDIT 7 (split file)

Gender		Frequency	Percent	Valid Percent	Cumulative Percent
Male	Never	70	86.4	86.4	86.4
	Less than monthly	5	6.2	6.2	92.6
	Monthly	1	1.2	1.2	93.8
	Weekly	2	2.5	2.5	96.3
	Daily or almost daily	3	3.7	3.7	100.0
	Total	81	100.0	100.0	
Female	Never	193	93.2	93.2	93.2
	Less than monthly	8	3.9	3.9	97.1
	Monthly	2	1.0	1.0	98.1
	Weekly	1	.5	.5	98.6
	Daily or almost daily	3	1.4	1.4	100.0
	Total	207	100.0	100.0	

AUDIT 8 Q) How often during the last year have you been unable to remember what happened the night before because of your drinking?

AUDIT 8 (overall scores)

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid Never	268	93.1	93.1	93.1
Less than monthly	10	3.5	3.5	96.5
Monthly	3	1.0	1.0	97.6
Weekly	2	.7	.7	98.3
Daily or almost daily	5	1.7	1.7	100.0
Total	288	100.0	100.0	

Split file – gender and AUDIT 8

AUDIT 8 (split file)

Gender		Frequency	Percent	Valid Percent	Cumulative Percent
Male	Never	73	90.1	90.1	90.1
	Less than monthly	1	1.2	1.2	91.4
	Monthly	1	1.2	1.2	92.6
	Weekly	2	2.5	2.5	95.1
	Daily or almost daily	4	4.9	4.9	100.0
	Total	81	100.0	100.0	
Female	Never	195	94.2	94.2	94.2
	Less than monthly	9	4.3	4.3	98.6
	Monthly	2	1.0	1.0	99.5
	Daily or almost daily	1	.5	.5	100.0
	Total	207	100.0	100.0	

AUDIT 9 Q) Have you or someone else been injured because of your drinking?

AUDIT 9 (overall scores)

	Frequency	Percent	Valid Percent	Cumulative Percent
No	267	92.7	92.7	92.7
1	1	.3	.3	93.1
Valid Yes, but not in the last year	16	5.6	5.6	98.6
Yes, during the last year	4	1.4	1.4	100.0
Total	288	100.0	100.0	

Split file – gender and AUDIT 9

AUDIT 9 (split file)

Gender		Frequency	Percent	Valid Percent	Cumulative Percent
Male	No	71	87.7	87.7	87.7
	1	1	1.2	1.2	88.9
	Yes, but not in the last year	8	9.9	9.9	98.8
	Yes, during the last year	1	1.2	1.2	100.0
	Total	81	100.0	100.0	
Female	No	196	94.7	94.7	94.7
	Yes, but not in the last year	8	3.9	3.9	98.6
	Yes, during the last year	3	1.4	1.4	100.0
	Total	207	100.0	100.0	

AUDIT 10 Q) Has a relative, friend, doctor or health care worker been concerned about your drinking or suggested you cut down?

AUDIT 10 (overall scores)

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	269	93.4	93.4	93.4
	Yes, but not in the last year	8	2.8	2.8	96.2
	Yes, during the last year	11	3.8	3.8	100.0
	Total	288	100.0	100.0	

Split file – gender and AUDIT 10

AUDIT 10 (split file)

Gender		Frequency	Percent	Valid Percent	Cumulative Percent
Male	No	71	87.7	87.7	87.7
	Yes, but not in the last year	4	4.9	4.9	92.6
	Yes, during the last year	6	7.4	7.4	100.0
	Total	81	100.0	100.0	
Female	No	198	95.7	95.7	95.7
	Yes, but not in the last year	4	1.9	1.9	97.6
	Yes, during the last year	5	2.4	2.4	100.0
	Total	207	100.0	100.0	

AUDIT Sub-domain scores overall:

HAZARDOUS SCORES (COMBINED)

	Frequency	Percent	Valid Percent	Cumulative Percent
Low	237	82.3	82.3	82.3
Medium	38	13.2	13.2	95.5
High	13	4.5	4.5	100.0
Total	288	100.0	100.0	

(13.2 + 4.5 = 17.7)

DEPENDENCE SCORES (COMBINED)

	Frequency	Percent	Valid Percent	Cumulative Percent
Low	278	96.5	96.5	96.5
medium	5	1.7	1.7	98.3
high	5	1.7	1.7	100.0
Total	288	100.0	100.0	

(1.7 + 1.7 = 3.4)

HARMFUL SCORES (COMBINED)

	Frequency	Percent	Valid Percent	Cumulative Percent
low	276	95.8	95.8	95.8
medium	3	1.0	1.0	96.9
high	9	3.1	3.1	100.0
Total	288	100.0	100.0	

(1.0 + 3.1 = 4.1%)

Split files – gender and AUDIT sub-domain scores

HAZARDOUS SCORES FOR MALES AND FEMALES SEPERATELY

Gender		Frequency	Percent	Valid Percent	Cumulative Percent
Male	Low	57	70.4	70.4	70.4
	Medium	16	19.8	19.8	90.1
	High	8	9.9	9.9	100.0
	Total	81	100.0	100.0	
Female	Low	180	87.0	87.0	87.0
	Medium	22	10.6	10.6	97.6
	High	5	2.4	2.4	100.0
	Total	207	100.0	100.0	

(Males – 19.8 + 9.9 = 29.7%; Females – 10.6 + 2.4 = 13%)

DEPENDENCE SCORES FOR MALES AND FEMALES SEPERATELY

Gender		Frequency	Percent	Valid Percent	Cumulative Percent
Male	Low	76	93.8	93.8	93.8
	medium	1	1.2	1.2	95.1
	high	4	4.9	4.9	100.0
	Total	81	100.0	100.0	
Female	Low	202	97.6	97.6	97.6
	medium	4	1.9	1.9	99.5
	high	1	.5	.5	100.0
	Total	207	100.0	100.0	

(Males – 1.2 + 4.9 = 6.1%; Females – 1.9 + .5 = 2.4%)

HARMFUL SCORES FOR MALES AND FEMALES SERPERATELY

Gender		Frequency	Percent	Valid Percent	Cumulative Percent
Male	low	75	92.6	92.6	92.6
	medium	1	1.2	1.2	93.8
	high	5	6.2	6.2	100.0
	Total	81	100.0	100.0	
Female	low	201	97.1	97.1	97.1
	medium	2	1.0	1.0	98.1
	high	4	1.9	1.9	100.0
	Total	207	100.0	100.0	

(Males – 1.2 + 6.2 = 7.4%; Females – 1.0 +1.9 = 2.9%)

Appendix 6

Most frequently reported alcoholic drinks consumed by older adults

<u>Alcoholic beverage</u>	<u>Number of participants</u>	<u>Percentage</u>
Wine	161	55.9%
Champagne	18	6.3%
Ale	12	4.2%
Lager	34	11.9%
Beer	50	17.4%
Cider	18	6.3%
White cider	5	1.7%
Gin	33	11.5%
Vodka	25	8.7%
Rum	11	3.8%
Whisky	49	17%
Tequila	0	0%
Brandy	25	8.7%
Liquors	18	6.3%
Baileys	3	1%
Port	3	1%
Sherry	4	1.3%

Appendix 7

AUDIT Questions and Optional Answers

1. How often do you have a drink containing alcohol?

- Never
- Monthly or less
- 2 to 4 times a month
- 2 to 3 times a week
- 4 or more times a week

2. How many drinks containing alcohol do you have on a typical day when you are drinking?

- 1 or 2
- 3 or 4
- 5 or 6
- 7 to 9
- 10 or more

3. How often do you have 5 or more drinks on one occasion?

- Never
- Less than Monthly
- Monthly
- Weekly
- Daily or almost daily

4. How often during the last year have you found that you were not able to stop drinking once you had started?

- Never
- Less than monthly
- Monthly
- Weekly
- Daily or almost daily

5. How often during the last year have you failed to do what was normally expected of you because of drinking?

- Never
- Less than monthly
- Monthly
- Weekly
- Daily or almost daily

6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?

- Never
- Less than monthly
- Monthly
- Weekly
- Daily or almost daily

7. How often during the last year have you had a feeling of guilt or remorse after drinking?

- Never
- Less than monthly
- Monthly
- Weekly
- Daily or almost daily

8. How often during the last year have you been unable to remember what happened the night before because of your drinking?

- Never
- Less than monthly
- Monthly
- Weekly
- Daily or almost daily

9. Have you or someone else been injured because of your drinking?

- No
- Yes, but not in the last year
- Yes, during the last year

10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?

- No
- Yes, but not in the last year
- Yes, during the last year

Appendix 8

Postcode Breakdown

Note: A total of 10 participants did not fill this information in (3.5%)

Cardiff central/Cardiff south

Postcode **CF10** = 5.4% (N=15)

- Covers part of Cardiff central, Grangetown, part of Cardiff Bay & Butetown

Cardiff central/Cardiff south

Postcode **CF11** = 1.1% (N=3)

- Covers part of Cardiff central, Canton, part of Cardiff Bay & Grangetown

Cardiff North (west)

Postcode **CF14** = 14.3% (N=40)

- Covers Birchgrove, Whitchurch, Thornhill, Lisvane, Rhiwbina, Pantmawr, Gabalfa, Heath, Llandaff North & Llanishen

Cardiff West (North)/Rhondda Cynon Taff

Postcode **CF15** = 1.8% (N=5)

- Covers Pentyrch, Gwaelod-y-Garth, Creigiau, Radyr, Morganstown, Tongwynlais, Taffs well & NantGarw

Cardiff North (East)

Postcode **CF23** = 4.7% (N=13)

- Covers Llanishen, Cyncoed, Pentwyn, Penylan, Pontprennau & Old St Mellons

Cardiff Central

Postcode **CF24** = .7% (N=2)

- Covers part of Cardiff city centre, Cathays, Roath, Plasnewydd, Splott & Adamsdown

Cardiff South (East)/Newport West

Postcode **CF3** = 19.5% (N=63)

- Covers Rumney, Trowbridge, Llanrumney, St Mellons, Castleton & Marshfield

Bridgend/Vale of Glamorgan

Postcode **CF32** = 1.1% (N=3)

- Covers Cefn Cribwr, Laleston, Merthyr Mawr, Ogmore Vale, Tondu, Sarn, Ynysawdre, St Brides Minor, Pontycymer, Llangeinor, Garw Valley, Blaengarw, Blackmill, Bettws, Aberkenfig & St Brides Major

Llantwit Fardre community/Llantrisant community

Postcode **CF38** = .4% (N=1)

- Covers Llantwit Fardre, Church Village, Tonteg, Efail Isaf, Beddau & Ty Nant

Cardiff West (South)/Vale of Glamorgan

Postcode **CF5** = 23.7% (N=66)

- Covers Ely, Caerau, St Fagans, Culverhouse Cross, Canton, Leckwith, Fairwater, Danescourt, Llandaff, Riverside, Wenvoe, Peterston Super Ely, St Georges Super Ely & Michaelston

Llantwit Major Town

Postcode **CF61** = .8% (N=2)

- Covers Llantwit Major Town & Llan-maes

Barry

Postcode **CF62/CF63** = 17.3% (N=48)

- Covers Barry Town, Cadoxton, Barry Docks, Rhoose, St Athan, Llancafarn & Barry Island

Penarth/Dinas Powys

Postcode **CF64** = 8.3% (N=23)

- Covers parts of Penarth town, Dinas Powys, Sully & Llandough

Cowbridge

Postcode **CF71** = .7% (N=2)

- Covers Cowbridge town, St Brides Major, Welsh St Donats, Pendoylan, Llandow, Colwinston, Llanblethian, Penllyn & Llanfair

Pontyclun

Postcode **CF72** = .4% (N=1)

- Covers Pontyclun, Llantrisant town, Llanharan, Talbot Green, Brynsadler, Miskin, Brynna & Llanharry.

**For more information please
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**From all of us,
THANK YOU!**

