

Working with Older Drinkers



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Background

Evidence suggests that the UK may be on the cusp of an epidemic of alcohol-related harm amongst older people:

- An estimated 1.4 million people aged 65 and over currently exceed recommended drinking limits¹.
- 3% of men and 0.6% of women aged 65-74 are alcohol dependent (NHS Information Centre 2009).
- There has been a steady increase in the amount of alcohol consumed by older age groups in recent years (Smith and Foxcroft 2009).
- The sizeable cohort of 'baby-boomers', currently aged 46-65, consume more alcohol than any previous generation (NHS Health Scotland 2006).

Findings presented in this report demonstrate that older drinkers have different stressors, precipitating factors and risk factors for relapse than younger drinkers. They also face a number of unique barriers to treatment and are more likely to remain 'hidden' from services. Despite these challenges, age-specific practices required to meet the needs of older people and draw them into treatment are poorly understood.

The purpose of this project was to develop guidelines on what strategies and treatment approaches are likely to work best with older drinkers based on synthesis of relevant literature, insight from alcohol practitioners who specialise in working with older people and the perspectives of older people receiving alcohol treatment. A set of concise guidance documents will be prepared for health and social care workers and alcohol service providers in due course.

Method

Literature Review

The literature review sought to identify international research relating to the nature of problem alcohol use amongst older people and strategies and interventions for working with older drinkers. Keywords relevant to the subject area were used to identify unpublished reports and articles published in peer reviewed journals. Peer reviewed articles were identified using a search of a cross-disciplinary collection of 40 of the largest and most commonly used databases including Academic Search Complete, JSTOR and Web of Science. Articles published prior to 1970 were excluded. Reports were identified using the Google search engine.

Interviews and Focus Groups with Practitioners

Through our professional networks we identified and approached five substance misuse treatment agencies who deliver services specifically for older substance users. One declined to take part in the study. The key features of the four services that did participate are described in Table 1.

A combination of one to-one in-depth interviews and focus groups were conducted with fifteen practitioners or practitioner/managers to explore the nature of drinking in old age, the characteristics of older drinkers

¹ Based on population estimates from the Office for National Statistics and data on alcohol consumption from 2008 General Household Survey

and the most effective strategies for working with them. Interviews/focus groups were audiotaped and transcribed. Data was analysed using thematic analysis (Miles and Huberman 1994).

Interviews and Focus Groups with Older People

Staff at each service were asked to approach older people (aged 50 and over²) who were currently receiving treatment for an alcohol problem in their service to invite them to take part in the study. All but one of those approached consented. One-to-one interviews were carried out with 11 older people (8 men and 3 women) aged between 55 and 73 and a further 15 older people (12 men and 3 women) aged 50 and over took part in a focus group.

Interviews/focus groups were conducted at the premises of the service that the older person attended. Questions focused on exploring their experiences of drinking, their needs in terms of treatment and the extent to which they felt that their needs had been met. The interviews and focus groups were audiotaped and transcribed. Data was analysed using thematic analysis (Miles and Huberman 1994).

To ensure the anonymity of the older people, their names and the names of their practitioners have been changed.

Definitions

Older People: For the purposes of this report, an 'older person' is someone aged 50 and over as this was the lowest threshold of eligibility for treatment in the older peoples' services that took part in this study.

Problem Drinking: Use of alcohol at a level which can cause psychological, physical or social harm.

Early-Onset drinker: An individual who started drinking problematically before the age of 40 (Widner and Zeichner 1991).

Late-Onset Drinker: An individual who started drinking problematically after the age of 40 (Widner and Zeichner 1991; Resnick and Junlapeeya 2004).

Project Limitations

This study has limitations. Firstly, the older people that we interviewed were all receiving treatment in specialist alcohol services, therefore they may be different to older problem drinkers who receive brief interventions in a non-addiction setting or remain hidden from services. Secondly, as it was staff from the services that invited service users to take part in the study, there may be an element of selection bias. Thirdly, as we interviewed the older people at the service premises, this may have prevented older people who find it difficult to leave their home, or are reluctant to do so, from taking part in the study. And finally, we spoke to a relatively small sample of older people and practitioners therefore there may be views or experiences that we did not capture during this study.

² See definitions section.

Table 1 Key features of the older peoples' substance misuse services that participated in study

Name of Service	Location	Established	Core Staff	Target Population	Length of Treatment	Home Visits Offered?	Accept Self-Referrals?	Key Elements of the Model	Primary Interventions
Addaction Over 50's Project	Glasgow	2009	3 FT	Substance users aged 50+ in the west of Glasgow.	Unlimited.	Y	Y	<ul style="list-style-type: none"> Assertive outreach. Social and leisure activities. Family involvement. Advocacy. 	<ul style="list-style-type: none"> One-to-one counselling. SMART recovery. Motivational Enhancement Therapy. CBT.
Addiction NI Older Focus Service	Belfast	1997	3 FT, 2 PT	Substance users aged 55+ throughout Northern Ireland (except Western Trust area).	Generally up to 16 sessions although degree of flexibility.	Y	Y	<ul style="list-style-type: none"> All staff from social work background. Family involvement and family support group. Outreach work. Education, training and consultancy for professionals. 	<ul style="list-style-type: none"> One-to-one counseling. Motivational Interviewing. CBT.
Aquarius Older Peoples' Service	Birmingham	2010	1 FT	Substance users aged 55+ Birmingham.	Unlimited.	Y	N	<ul style="list-style-type: none"> Research component. Outreach work. Family involvement. Linked to Aquarius hospital-based team. 	<ul style="list-style-type: none"> One-to-one counseling. Motivational Interviewing. CBT. Social Behaviour and Network Therapy.
Foundation 66 – two older peoples' services in Hammersmith & Fullham (H&F) and Kensington & Chelsea (K&C)	London	H&F: 2009 K&C: 2008	2 FT	H&F: Substance users aged 50+. K&C: Substance user aged 60+.	H&F: up to 6 sessions although degree of flexibility. K&C: unlimited.	Y	Y	<ul style="list-style-type: none"> Multidisciplinary (nurse and social worker/psychologist). Embedded in primary & secondary health care and social services. Education, training and awareness raising. Outreach work. 	<ul style="list-style-type: none"> One-to-one counseling. Motivational Interviewing. Harm reduction.

Results

The results that follow are a synthesis of the findings from the literature review and interviews/focus groups with specialist alcohol practitioners and their clients.

Nature of Drinking

As individuals become older, they often experience multiple losses, for example, loss of family, friends and health, and changes in role such as retirement or becoming a caregiver for an elderly partner or relative. Additional stressors (e.g. chronic pain or insomnia) and multiple crises (e.g. economic and health problems) may result in an overwhelming situation in which alcohol misuse may begin or increase. Approximately one third of older drinkers, known as 'late-onset' drinkers, first develop a drink problem in later life (Widner and Zeichner 1991; Dufour and Fuller 1995; Mellor, Garcia et al. 1996). The other two thirds of older drinkers, known as 'early-onset' drinkers develop an alcohol problem earlier in life (by definition, before the age of 40 (Widner and Zeichner 1991)). Box 1 illustrates some of the life changes that may be associated with alcohol problems in older people.

Box 1 - Life changes that may be associated with alcohol problems (adapted from Dar 2006)

Emotional and social

- Bereavement
- Loss of friends and social status
- Loss of occupation
- Impaired ability to function
- Family conflict
- Reduced self-esteem
- Caring for elderly partner or family member
- Loss of independence

Health

- Physical disabilities
- Chronic pain
- Insomnia
- Sensory deficits
- Reduced mobility
- Cognitive impairment

Practical

- Needing assistance with activities of daily living
- Reduced coping skills
- Altered financial circumstances
- Moving into residential care

Not surprisingly, early-onset drinkers are more likely than late-onset drinkers to have a history of treatment for alcohol use (Fingerhood 2000). Some of the practitioners that we spoke to during the study pointed out

that as early-onset drinkers have often had multiple experiences of treatment where they have not achieved their goals, this can create a sense of low self-esteem and self-efficacy. In contrast, many late-onset drinkers may not know what alcohol treatment is available, where to go for help or what to expect:

“I had never heard of [name of service] who they were, what they did and everything. And she [alcohol worker] explained about this home detox and I said what do you mean, what is a home detox.....³ I was no naive about things..... You don’t know what to expect when you first come to a place like this. All sorts of things go through your mind, oh what on earth are they going to think about you drinking a litre bottle of vodka, what will they think.” (Betty, 61, late onset)

We interviewed Jim, a late-onset drinker, who had started using alcohol to cope with the stresses of caring for his wife:

“My wife at that time was diagnosed with MS.... I think I really started drinking then slowly. I had always had a drink, Friday night or Saturday night, there was always drink in the house, it didn’t bother me... She came to rely on me, because she had to give up work in the end.....I had to pack up work. I was a full time carer for 12-14 years. Drinking got worse. Secret drinking, not going out, I would go in the pub for a pint... I had a stash on the veranda where I could sneak out and have a drink. My excuse was taking the dogs out and I had my big coat on so I could fill the pockets up with beer. Then it was other spirits as well, so it was strong Tennents, probably vodka because supposedly there is no smell.... I was taking cans down to the allotment and drinking there secretly... I was still able to cope looking after her. When I went to bed, I used to take cans up there, strong stuff, and I used to sleep for a couple of hours. Most people would have a glass of water, I didn’t, I would have a can. And we had two bathrooms one on the bedroom level and one on the downstairs level. And I would come down to the downstairs level but she would hear me because she was on the bedroom level and she said ‘why do you go to the toilet downstairs?’ And I said ‘to stop disturbing you’. It wasn’t, it was to get a top up wasn’t it. Because I had run out of my cans upstairs, so I would have to come downstairs, have a slurp and I would be OK for the next couple of hours.” [Jim, 62, late-onset].

Another interviewee, Alan, was an early-onset drinker whose drinking was a continuation of a life-long pattern of alcohol misuse:

“Maybe in High School I drank to excess, I drank maybe initially once a month and we developed a tradition of having parties every week but everybody did that, and I didn’t get into it.... But when I was studying architecture at university, I can remember through my final years I was obviously getting something through architecture, other things because I didn’t need to drink.... And it only kicked in when I was in my thirties and I joined a very famous architects office....I thought fuck, this is such an important job and I don’t want to blow it, I will go the pub and socialise because I hadn’t done that before. And then they were all drinking quite heavily, work hard, play hard. And I did that for a year and everyone else stopped, they got tired of it, but I didn’t.” (Alan, 61, early-onset)

Older people are at greater risk of being socially isolated than younger people (Iliffe, Kharicha et al. 2007) and feelings of loneliness are not uncommon among this group (Victor, Scambler et al. 2005; Theeke 2009). Hanson (1994) examined the relationship between social networks and heavy drinking in a random sample

³ ‘.....’ denotes text deletion

of 500 men who were all 68 years old at the time of the study. Results showed that heavy drinkers were more likely to live alone, had fewer contacts with friends and family, less participation in social events and a less integrated social network.

Practitioners in our study observed that social isolation appeared to be both a cause and symptom of problematic drinking in some of their clients:

“Social isolation is a big factor for [older] people.... Loneliness would be something that clients will talk about often and struggling to cope with that and using alcohol to cope with that.” (Practitioner, Addiction NI Older Focus Service, Belfast)

“Many of them have been drinking from many, many years although when they come to retirement or they are widowed or whatever, then their drinking does get worse, ‘what am I going to do with this time, how am I going to fill my days’. Loneliness, boredom is a huge thing....Estranged from their families, their families are fed up with their drinking behaviour. Isolation, very much so.” (Practitioner, Foundation 66 Older Peoples’ Service, London)

Data from a national household survey demonstrates that those aged 65 and over are more likely to drink every day, drink at home and drink alone than any other age group (Lader and Steel 2009). Irene told us that she drank almost exclusively at home:

“My mother needed a hip replacement and she lived at home with me... And a short time after that, say a year after that, the GP referred her to the memory clinic, they said she had Alzheimer’s....She was bed-ridden....But once she started to have the Alzheimer’s and I was looking after her, I was taking a drink and giving her a wee drink to be honest with you... Mum was with me for 6 years.... When I was coming home from work, I was starting to go to the off-licence and get a bottle of vodka. And then I would cook her dinner for the next couple of days and puree her food and wash her clothes, and line it all up for her. And then I was taking one to calm me down.” (Irene, 60, late-onset).

Practitioners noted that many older people who are unwilling or unable to leave the home to buy alcohol, have it delivered:

“The dependent home-based drinkers do have it delivered. If someone wants to drink they will find ways and means of getting alcohol. In the first year [of our older peoples’ service] everyone had a deal with an off-licence, they kept their pension book, they didn’t have to leave the house to get their alcohol.... In the first year, literally everyone. It was the nature of someone not having to do the shopping, of being more isolated, drinking is less of a social activity [for some older people].” (Manager, Foundation 66 Older Peoples’ Service, London)

An inability to purchase alcohol leaves some older people vulnerable to exploitation and older people may be encouraged to drink by carers to make them more compliant:

“A couple I worked with...very vulnerable...the high risk for them is that they were targeted by some of the local drug users who would knock on the door and offer to go and get their alcohol for them....They were stealing the money from them.....Sometimes they would come back with the whisky and sometimes they wouldn’t but they would be getting what they needed. Bang, banging on the door at all times of night.” (Manager, Aquarius Older Peoples’ Service, Birmingham)

“[To other service workers] I’m sure you have come across cases as well when you come across a family member who almost tries to control the client by enabling them to drink.....It is a really mild form of abuse...You don’t want them to stop drinking, you want to isolate and contain them. And caregivers get engaged in controlling the patient by supplying alcohol. If you come to clean someone’s house and they are a drinker, and maybe they are too demanding, you give them a bottle, you do your cleaning and then you go...It is like controlling, here is your dose.....It is no different to giving them benzos to keep them in their chair.” (Manager, Foundation 66 Older Peoples’ Service, London)

It has long been recognised that some professionals enable older people to drink by purchasing alcohol for them (Herring and Thom 1997; Millard and McAuley 2008). Herring and Thom (1997) point out that in terms of problem drinkers, carers are faced with the difficult task of balancing ‘rights’ and ‘risks’ within a philosophy of community care which emphasises client choice and autonomy. Practitioners commented:

“Sometimes they [home carers] take a client in a wheelchair to the off-sales. They aren’t allowed to go personally and buy the alcohol. Even if the client is intoxicated, if the client is saying I want to go to the off-sales, they will push them.” (Practitioner, Addaction Over 50’s Project, Glasgow)

“I went to a review on Wednesday, mental health and he is in sheltered housing, he is really quite an ill man, he is suffering from malnutrition. He was saying [he drank] about 3-4 cans of Tennents per day, but also his memory, he is suffering from early dementia as well, he said his wife died two weeks ago, she died in 07, that kind of thing. So the manager of the mental health team from [name of psychiatric hospital] said ‘what if we bought a crate of beer a week and gave him two each day’.” (Practitioner, name of service withheld)

Data from national household surveys demonstrate that older men in the general population are most likely to drink beer, lager or cider whilst older women are most likely to drink wine (Lader and Steel 2009). Older people in alcohol treatment frequently consume spirits and the average alcohol consumption is high:

“Most of them will drink a litre of vodka, a bottle of brandy, per day I’m talking. So the amount they are drinking is huge.” (Practitioner, Foundation 66 Older Peoples’ Service, London)

Key Points

- Old age is associated with a number of life changes or transitions which can trigger (late-onset) or increase (early-onset) alcohol problems.
- Older drinkers are more likely to drink at home and are at risk of social isolation.
- Controlling the supply of alcohol to older drinkers can be used as a means to exploit them or make them more compliant.

Alcohol-Related Problems

Alcohol misuse in older people can be linked to, or exacerbate, a number of physical, mental, social and practical problems (Box 2). Some of these such as falls, elder abuse, and problems caused by combining alcohol with medications, are particularly associated with later life. However, others such as criminal behavior, suicide and difficulties with sexual relationships, challenge our stereotypes of older people. The following text discusses these problems using excerpts from our interviews with practitioners and older people to illustrate them.

Box 2 – Alcohol-related problems

Physical problems

- Major illness (Colsher and Wallace 1990)
- Coronary heart disease, hypertension and stroke (Department of Health 1995)
- Gastrointestinal problems (Tabloski and Church 1999)
- Parkinson's disease (Feuerlein and Reiser 1986)
- Liver problems including cirrhosis (Curtis, Geller et al. 1989; Smith 1995)
- Cancer of the liver, oesophagus, nasopharynx and colon (Curtis, Geller et al. 1989; Smith 1995)

Mental health problems

- Memory loss (Woodhouse, Keatinge et al. 1989)
- Dementia (Hislop, Wyatt et al. 1995; Thomas and Rockwood 2001)
- Depression (Woodhouse, Keatinge et al. 1989; Colsher and Wallace 1990)
- Suicide (Waern 2003)

Social problems

- Less satisfaction with life (Colsher and Wallace 1990)
- Social isolation (Hanson 1994)
- Separation or divorce (Ekerdt, deLabry et al. 1989)
- Elder abuse (Friedman, Avila et al. 2011)

Practical problems

- Falls (Wright and Whyley 1994; Ostbye, Walton et al. 2004; Sorock, Chen et al. 2006; Heuberger 2009)
- Insomnia (Tabloski and Church 1999)
- Incontinence (Tabloski and Church 1999)
- Interactions with medication (Dunne 1994; Moore, Whiteman et al. 2007)

Alcohol consumption in older people has been associated with falls (Wright and Whyley 1994) and falls with serious sequela (Ostbye, Walton et al. 2004; Resnick and Junlapeeya 2004) or death (Sorock, Chen et al. 2006; Heuberger 2009). This could be due to the fact that at the same peak level of blood alcohol concentration, the postural balance of older people is twice as impaired as younger adults (Vogel-Sprott and Barrett 1984). Practitioners described instances where their clients had multiple falls as a result of their alcohol use:

“[She] had been highlighted as being at risk by hospital staff because she kept going into hospital with lots of bruises, head injuries what have you. They thought the husband, they were both really frail, was hitting her. But it turned out the husband wasn’t hitting her, she kept falling out of bed. I suspect that she kept her alcohol on the side and she kept falling out of bed when she went to get it.” (Manager, Aquarius Older Peoples’ Service, Birmingham)

“I have got a man and he has got cirrhosis of the liver, he also has got cancer, he is in sheltered housing but he is 67 and he is more like an 87 year old physically, always falling. He has been to [name of hospital] I think 27 times in 6 months. He is only in for a couple of hours or maybe a night. He is black and blue with bruises but he never breaks anything.” (Practitioner, Foundation 66 Older Peoples’ Service, London)

A recent case-control study found that older people who were victims of severe physical abuse were more likely to have an alcohol problem (Friedman, Avila et al. 2011). Practitioners told us that elder abuse was something that they often encountered in their work:

“[Elder abuse] is an issue and sometimes it is in a discussion with our staff that it is the first time that the person has disclosed it and we have contacted social services. I would say that has happened on a number of occasions where you are aware that there is evidence of a range of abuses, financial abuse, elder abuse etc... It is obviously something that we would be aware of and try and pick up in assessment. But quite often it may have been that it hasn’t actually been discussed with other professionals, say with the GP, and it is in the work with our staff and having developed a relationship, they will be the person they feel able to talk to.” (Manager, Addiction NI Older Peoples’ Service, Belfast)

“There has been concerns about exploitation, not always from family, from neighbours and significant others. There is one at the moment we have been working with from when the project started. It has been a long process, he has alcohol related brain damage. He has a friend who helps him with his finances, and there is an issue whether he is taking advantage or not.” (Practitioner, Addaction Over 50’s Project, Glasgow)

Older people receive more prescriptions than any other age group and are often dispensed multiple medications (Crome and Crome 2005). Many medicines, both prescription and over the counter, interact with alcohol. These interactions may increase the effect of a medicine (e.g. the sedative effect of a hypnotic), exacerbate a side effect (e.g. the drowsiness associated with anti-histamine use), or result in a new syndrome (e.g. the unpleasant effects of combining alcohol and some antibiotics) (Moore, Whiteman et al. 2007). As the severity of these interactions differs, some medications require total abstinence from alcohol, whilst others require reduced alcohol use.

Practitioners emphasised the risks that can occur when older people combine alcohol with medications:

“Some people maybe aren’t aware or haven’t acknowledged that the warning [not to drink alcohol with medication] was there for a good reason. One that would come up fairly often would be in relation to sleeping medication, Temazepam, where the person is maybe having a nightcap as well. I remember at one stage I had quite a number of referrals and the reason was the person had fallen and it was quite obvious that the person was having a few vodkas at night and taking the sleeping medication and as a result they had fallen. They would say it couldn’t have been alcohol because it was next morning but explaining that the medication is still in the system that it probably had

resulted in a fall the next morning when they were coming down the stairs.” (Manager, Addiction NI Older Peoples’ Service, Belfast).

Criminal behaviour is associated with alcohol use. Whilst practitioners told us that self-reported offending was rare in their clients, a number of older people that we spoke to had been in trouble with the police.

“How has it affected me? I was very argumentative, not with my wife but with people, I was taking my temper out on them... One time we were going to the allotment, I would drive the car and she [wife] would come down in her wheelchair....We went past the doctors it wasn’t our doctors, down the road. And there was a car parked across this disabled ramp....So I got to the allotment with her and I went back. I parked on the island and I went past the car and I scratched it, two doors and a panel, with my car keys, what vandals would do. And eventually a woman come out with a baby and the receptionist and they seen my car. I drove off. This woman followed me all around [name of area] and I was up and down little roads, she was following me. Eventually I got to the allotment and I hid the car behind a hedge and I thought I was safe. The next Sunday, two weeks later, there is a card on the floor from the police. Can I get in touch with the police there has been an accusation so I went on the Tuesday. My problem was not having a drink to get there. I filled myself up with mints. So I got there and I had to make a statement and they arrested me. And I had to make a statement, fingerprints, photos, the lot. And they put me in a cell for my own benefit because footballers were coming in and the rest of it. They let me go but nothing happened.” [Jim, 62, late-onset].

Sid described an occasion where he assaulted his wife when drunk:

“I got violent with it....I got so violent the police were called... I had actually hit my wife and I couldn’t remember it. The minute that triggered off, I knew there was something desperately wrong. When you can’t remember. All I remember was sitting down, watching the telly and everything else was a blank until the police came.” (Sid, 58, late-onset)

Most older people consider sexual activity and associated feelings a natural part of later life (Beckman, Waern et al. 2008). Some of the older people that we spoke to alluded to the fact that alcohol had affected their sexual relationships:

“Initially it [discussion with alcohol practitioner] was just about alcohol, now it is just everything. It could be about sex...I wasn’t sure how comfortable she was....But then I just decided what the hell, she was just brilliant about it, very understanding. I thought because I’m a man and she’s a woman, it might be uncomfortable for her but it wasn’t.” (Alan, 61, early-onset)

An epidemiological study has demonstrated that the prevalence of depression in those aged 65 and over is 27% amongst those living in institutions and 9% amongst those living at home (McDougall, Matthews et al. 2007). Other studies have shown that older people have a higher risk of completed suicide than any other age group (O’Connell, Chin et al. 2004) and that alcohol problems (Waern 2003) and depression (O’Connell, Chin et al. 2004) are predictors of suicide in this population. Suicide is a significant cause for concern in clients attending alcohol services:

“Seven weeks ago I was going to commit suicide, I really was. Because I was on an eviction order here so they were going to sling me out on the street”. (Stan, 67, early-onset)

“One of the big issues we have would be in relation to suicidal ideation, it is a huge problem. We are regularly getting telephone calls from people saying that they are feeling suicidal. Or when the worker is out with a client at their home or in their session, people are reporting that.” (Manager, Addiction NI Older Focus Service, Belfast)

Key Points

- Alcohol misuse in older people is associated with a number of physical, mental, social and practical problems.
- Some alcohol-related problems experienced by older drinkers are specifically related to old age whilst others challenge stereotypes of older people.

Working with Older Drinkers

Barriers to Treatment

Alcohol problems in older people frequently remain undiagnosed. A British study reported that doctors are less likely to request an alcohol use history from older patients (Naik and Jones 1994) while an Australian study found that only a third of older problem drinkers were diagnosed following hospital admission (McInnes and Powell 1994). In a general hospital in the United States, over a 6 month period, medical staff correctly diagnosed only 37% of older patients with an alcohol problem compared to 60% of younger patients (Curtis, Geller et al. 1989). Older people are also less likely to have specialist alcohol treatment recommended by physicians and initiated when it is recommended (Curtis, Geller et al. 1989) and more likely to receive medical management for health problems caused by alcohol use rather than treatment for the alcohol problem itself (Moos, Mertens, & Brennan, 1993). Social care professionals who work with older people are less likely to ask about substance misuse than social care professionals working with younger people and are less likely to make referrals to specialist substance misuse services (Galvani, Dance et al. 2011).

Practitioners that we spoke to during the course of this study identified the following attitudes, lack of knowledge and awareness amongst professionals as a key barrier to treatment:

- Lack of awareness that alcohol misuse is a potentially important problem for older people
- Reluctance to ask embarrassing questions of older people
- Attitude that older people are too old to change their behaviour
- Lack of confidence in skills to take action
- Belief that it is wrong to 'deprive' older people of their 'last pleasure in life'
- Inability to identify signs and symptoms of alcohol problems in older people

It was evident from our interviews with older people that embarrassment and shame may prevent some individuals accessing treatment:

"I just like the one-to-one [therapy]. I am very afraid of going into a crowd [group therapy].....I think because it is a personal problem there is a terrible shame about it...I'm not having to share the shame with lots of people. It is terrible, terrible shame.... You see no one knows that I'm coming here, my husband knows, but he is the only one that knows and at this stage I'm not ready to tell them. It is all tied in with shame of my problem." (Wendy, 73, early-onset)

"I hadn't had a detox for a year. I went cold turkey all those times. And God that was terrible. Through embarrassment, through not wanting to say I'm in this state." (Russell, 57, early-onset)

Practitioners suggested that the stigma associated with drinking may be particularly profound for women and black and minority ethnic older people and this is reflected in help-seeking behaviour:

"Stigma and often, particularly women, you will find that it is very important for them to keep up their image. They can often present better, they will work hard at their appearance. They will still manage their hygiene and keep their house in decent order... A lot of them [GP's] are not noticing that there is an alcohol problem. So they might see a lady who is torted up and she has got her hair

done and she has got a nice coat on, they might just think she is having a tippie, they don't necessarily know what an impact that is having" (Practitioner, Addaction Over 50's Project, Glasgow)

"I did have one Indian lady, according to her and her son, alcohol is a big problem but people just won't go to any services, they don't want stigma attached to them. We have to work with her at home, she was referred to a day centre, it is an Asian day centre but she doesn't want the referral to come from the Community Addiction Team, so I had to go through the GP, because confidentiality is very, very important to her. We did invite her to a SMART group, but she was quite scared, was there anybody about, what if she was seen. It wasn't as if she was coming out of something with 'alcohol' written on it, but it is just that thing about being seen somewhere and having to explain to people what you are doing there... It took from July last year, to the beginning of this year to get her opening up and to talk. She started off saying I don't know why you are here but I'll make you a cup of tea." (Practitioner, Addaction Over 50's Project, Glasgow)

One practitioner suggested that mixed-age services may be inappropriate for older people and that this may be a barrier to treatment:

"Older people may not be as comfortable coming into organisations that are focusing on younger people. Even just things like the brightly coloured posters, the imagery that is all around and the sort of, that kind of ethos, that kind of environment which is great for young people and great for young person's services but with older people there is a stigma there, they are at a different stage in life." (Practitioner, Addiction NI Older Focus Service, Belfast)

Practitioners also stated that there were a number of practical barriers to attending services such as lack of transportation and mobility problems.

Key Points

- Lack of knowledge, awareness and ageist attitudes amongst professionals may prevent some older people receiving appropriate treatment.
- Embarrassment and shame and the cultural inappropriateness of mixed-age services may deter some older people from seeking treatment.
- Lack of transportation and mobility problems may make it difficult for some older people to attend services.

Contact and Engagement

Several of the older people that we spoke to sought help themselves for their alcohol problem:

"I knew then that something had got to stop, I had to go and get some help from somewhere. I took myself off to the GP who was a lovely, lovely person and she asked me how I felt about having some counselling with [name of service]. Well I had never heard of [name of service] then. I said 'I will try anything'." [Betty, 61, late onset]

“Four years ago, I ended up in [name of area where service is located] ... And I realised I was drinking too much....I went in there and I said, ‘Sir, I have got a drink problem’.” (Stan, 67, early onset)

For others, health and social services were instrumental in identifying the problem and referring the older person to treatment.

Practitioners took the view that a good rapport is vital when working with older people and that a non-threatening and unhurried approach is required to establish a rapport:

“I think the relationship is key in all our work but I think possibly more so with older people, maybe a number of the clients that we would work with have very limited support networks and a long history of alcohol has resulted in a breakup of the family and very little in the way of meaningful relationships.” (Practitioner, Addiction NI Older Peoples’ Focus, Belfast)

“Older people like to know a bit about you as well. And so you have to be mindful of the fact that they are exposing themselves to you and they are interested in you as well. So I think for me it is about being able to give them enough information to make them feel equal but ensure that you don’t get hooked into giving them too much information because you are still there as a professional. So that is a bit different in terms of how, for me personally, how those boundaries are not so rigid.” (Manager, Aquarius Older Peoples’ Service, Birmingham)

Key Points

- Health and social services have a key role to play in linking older people with alcohol services but some older people will seek help directly.
- Establishing a good rapport is particularly important when working with older drinkers.

Screening and Assessment

Appropriate screening tools can be useful in identifying alcohol problems in older people (Royal College of Psychiatrists 2011). Some of the physical signs and symptoms that should trigger screening in older people are listed in Box 3. Traditionally health and social care providers have relied on screening tools such as the Alcohol Use Disorders Identification Test (AUDIT) (Saunders, Aasland et al. 1993; Bush, Kivlahan et al. 1998), CAGE (Mayfield, McLeod et al. 1974; Ewing 1984) and MAST (Selzer 1971; Selzer, Vinokur et al. 1975; Blow, Gillespie et al. 1998). However, these tools focus on personal feelings and consequences of use that have less relevance for older people. Furthermore, as older people are more sensitive to the effects of alcohol due to the physiological effects of ageing (Smith 1995), screens such as AUDIT which use amount of drinking to define hazardous drinking, may be poor indicators of alcohol problems in older people. Finally, medical conditions or medications that are particularly likely to place older people at adverse risk of health events are not addressed by these screens.

A small number of screening tools have been developed specifically for use with older people. The Michigan Alcohol Screening Test – Geriatric Version or MAST-G (Blow, Brower et al. 1992) and its shortened version, SMAST-G (Blow, Gillespie et al. 1998) are paper-based screening tools and include questions which focus on

problems that are commonly associated with drinking in older people, for example, 'when you feel lonely does having a drink help' and 'have you ever increased your drinking after experiencing a loss in your life'.

The Alcohol-Related Problems Survey or ARPS (Fink, Tsai et al. 2002) and its derivatives the Shortened Alcohol-Related Problems Survey or shARPS (Moore, Beck et al. 2002) and the Comorbidity Alcohol Risk Evaluation Tool or CARET (Moore, Beck et al. 2002), aim to detect older people who are at risk of or experiencing problems because of their use of alcohol in conjunction with comorbidities, medication use and functional status. ARPS is limited by its requirement to be scored by a computer but shARPS can be hand-scored.

Current evidence suggests that ARPS and its derivatives may be the most appropriate screening tools for use with older drinkers followed by SMAST-G and AUDIT (Morton, Jones et al. 1996; Moore, Beck et al. 2002; Berks and McCormick 2008). ARPS focuses on physical health therefore it may be most appropriate for healthcare settings. Interpretation of data on comparisons of screening tools is complex and work in this area is ongoing.

Box 3 Physical signs and symptoms that should trigger screening (Blow, Gillespie et al. 1998)

- Sleep complaints
- Cognitive impairment, memory or concentration disturbance
- Seizures, malnutrition, muscle wasting
- Liver-function abnormalities
- Persistent irritability without obvious cause
- Unexplained chronic pain or other somatic symptoms
- Incontinence, urinary retention
- Poor hygiene and self-neglect
- Unusual restlessness and agitation
- Complaints of blurred vision or dry mouth
- Unexplained nausea and vomiting
- Changes in eating habits
- Slurred speech
- Tremor, poor motor coordination, shuffling gait
- Frequent falls and unexplained bruising

Practitioners interviewed during this study advised that assessments should be comprehensive and include physical and mental health, social activities, interpersonal relationships, the physical environment, competency with activities of daily living, safety needs and coping response (Box 4).

Some practitioners recommended a move away from the standard structured question-and-answer type format of assessments, preferring to allow the information to be gathered informally once the relationship has been properly established. Others reported that there was a need to develop age-specific, standardised assessments tools.

A number of practitioners observed that older people may find it difficult to gauge how much alcohol they are consuming:

“One person that I worked with, she likes her ‘tot’, it helped her sleep and the idea of giving up her tot was really not on. She was worried about not being able to sleep... So then we looked at what her tot was, because I was at home with her, she went to the kitchen and she pours me her tot and we have got half a tumbler she fills up with whisky and then she fills that up with lemonade and hot water. But it is a good slug, you are talking about three or four units in one go.... Then you discover that the tot is just what she is having at bedtime, might have a bottle of wine at lunchtime, might have a bit of something else and have half a bottle of whisky during the day. And the falls then start to make sense.” (Manager, Aquarius Older Peoples’ Service, Birmingham).

“I think that one of the things that I have found useful is rather than talking about units, most of our clients would drink spirits, and talk about when did you purchase the bottle and how long did that last. So I got it on the Tuesday and how much did you have left by the end of the week. I think for a lot of the older clients, units mean nothing.” (Practitioner, Addiction NI Older Peoples’ Service, Belfast)

Key Points

- Screening tools developed specifically for older people are preferable to generic screening tools.
- Assessment should include quality of life issues and competency with activities of daily living as well as alcohol use.
- Older people may find it hard to gauge how much they are drinking.

Box 4 – Issues other than substance misuse for assessment

Physical health

- Existing illness
- Mobility
- Sensory limitations
- Nutrition
- Pain
- Sleep problems
- Self-care
- Medication use

Mental health

- Memory and cognitive impairments
- Dementia
- Depression and anxiety
- Suicidal ideation
- Coping mechanisms

Social

- Social activities
- Interpersonal and family relationships
- Family and caregiver stress
- Susceptibility to elder abuse
- Social and professional support

Practical

- Safety needs
- Falls
- Competency with activities of daily living such as bathing, dressing and preparing meals.

Treatment

Evidence suggest that older people are more adherent to alcohol treatment than younger adults (Oslin, Pettinati et al. 2002), and are just as likely to benefit from it (Oslin, Pettinati et al. 2002; Lemke and Moos 2003). Late-onset drinkers may be particularly receptive to treatment (Menninger 2002). Even a one-time brief encounter of 15 minutes or less can reduce non-dependent problem drinking by more than 20% (US Department of Health and Human Services 1998).

The great heterogeneity of this client group means that treatment must be tailored to individual needs. A practitioner commented:

“Although the clients we work with are all over 55, there is such a range of experiences that they bring to the relationship, there is no particular method or style of intervention that works particularly well, it is particular to that person.” (Practitioner, Addiction NI Older Peoples’ Service, Belfast)

Practitioners suggested that treatment goals should be set by the client and focus on quality of life in addition to issues surrounding alcohol. For example counselling, may need to target areas such as depression and loneliness. Where social isolation is an issue, the client may require assistance identifying opportunities for social activities and connections to the community:

“One woman is attending a knitting group. I helped identify it, so what are we going to do there, she could have identified to me that she had been coming home that she was a bit tired, she didn’t feel she was speaking to people, she was in the house all day every day, she didn’t have a routine..... One client for his care plan is to learn how to text....He has never touched a computer, so his goal is to learn to text so he can communicate with family and friends.” (Practitioner, Addaction Over 50’s Project, Glasgow)

Practitioners also emphasised the fact that the duration and frequency of treatment should be individualised and guided by client need and that it is important that older people be given the option of receiving treatment in their own home:

“I think with a lot of older people the work is long term because the issues are complex. Some people won’t need long term help. But I kind of feel to expect an older person to change behaviour that has become so entrenched in a time-limited piece of work is very optimistic.” (Manager, Aquarius Older Peoples’ Service, Birmingham)

“From the outset we said that we wanted to make the service as accessible as possible so one of the things that we did was to offer the choice of domiciliary appointments. I think that played a big part both in relation to the physical and also the psychological barriers, that people could actually be seen in their own homes. I think it stopped a lot of the stigma and embarrassment for people as well, particularly for women. I think there was a lot of stigma in admitting that there was a problem, yet alone in going to an agency so I think that the choice of domiciliary appointments made a difference.” (Manager, Addiction NI Older Focus Service, Belfast)

Practitioners were keen to stress that the complex needs of some older drinkers require effective case management and good collaboration and communication with colleagues:

“I think the difference with older people is that they become so isolated and don’t know what is available to them and need more support in order to access services.”(Manager, Aquarius Older People’s Service, Birmingham)

“Because of the complexity you really have to work in partnership, there are always going to be medical staff, care providers, substance misuse services. How we work together is defining how good the service is that they are receiving... Alcohol generally is a complicated problem and ageing is as well, only with a group of professionals can you give a full service.” (Manager, Foundation 66 Older People’s Service, London)

Older people, particularly those clients that have low self efficacy as a result of repeated experienced of failed alcohol treatments, are likely to benefit from a strengths based approach:

“One of the big things I think in working with the client group is around the whole issue of identifying strengths. Because that is a big, big problem people are maybe feeling that they would like to change but they themselves feeling that they can’t do it. They might look on their lives as a succession of failures, several of the people we see would have had any number of previous contacts with treatment agencies and they would think, well that didn’t work 20 years ago and I think a big part is helping people identify strengths.” (Practitioner, Addiction NI Older Focus Service, Belfast).

A study has found that the concerns of family members and friends were the most common factor motivating older people to seek for treatment for alcohol problems (Finlayson, Hurt et al. 1988) and obtaining help from family members and friends has been shown to lower the likelihood of alcohol-related problems in older drinkers (Moos, Schutte et al. 2004). In a review of alcohol problems in ageing families, Stelle and Scott (2007) conclude that a family-oriented approach to intervention may best serve the needs of older drinkers. Practitioners that we spoke to felt that family, caregiver and friend involvement could be very valuable although they stressed that it must only take place with the client’s consent and where it is safe to do so:

“When at all possible involve any significant others, the family. Because if you are talking and supporting the family you have a better chance... Sometimes that [working with families] is more harmful than good....Sometimes families have got their own agenda.” (Practitioner, Addaction Over 50’s Project, Glasgow)

A focus group that we carried out with an older peoples’ SMART group suggested that older people may benefit from peer support:

“I have enjoyed this group. We have got so much in common.”

“This is a fantastic group, we have all become friends.”

“It is great coming in here we don’t look down on one another, we have all got the same problems, we can all talk about it.... we all look after each other, if someone doesn’t come, we worry about them and think, are they back on a binge or ill.”

Sorocco and Ferrell (2006) suggest that older people who drink above recommended levels where there is no evidence of alcohol dependence should receive a brief intervention whilst older people who are alcohol dependent should be referred to specialist services for additional evaluation and treatment. The US Department of Health and Services (1998) recommends the following brief intervention:

1. Customised feedback on screening questions relating to drinking patterns and other health habits such as smoking and nutrition.
2. Discussion of types of drinkers and where the patient's drinking patterns fit into the population norms for his or her age group.
3. Reasons for drinking. This is particularly important because the practitioner needs to understand the role of alcohol in the context of the older patient's life, including coping with loss and loneliness.
4. Consequences of heavier drinking. Some older patients may experience problems in physical, psychological, or social functioning even though they are drinking below cutoff levels.
5. Reasons to cut down or quit drinking. Maintaining independence, physical health, financial security, and mental capacity can be key motivators in this age group.

6. Sensible drinking limits and strategies for cutting down or quitting. Strategies that are useful in this age group include developing social opportunities that do not involve alcohol, getting reacquainted with hobbies and interests from earlier in life, and pursuing volunteer activities, if possible.
7. Drinking agreement in the form of a prescription. Agreed-upon drinking limits that are signed by the patient and the practitioner are particularly effective in changing drinking patterns.
8. Coping with risky situations. Social isolation, boredom, and negative family interactions can present special problems in this age group.
9. Summary of the session.

Empirical data on what interventions work best with older people are limited but it is generally acknowledged that empirically supported treatments in adults can be successfully applied to the treatment of older people (Kalapatapu 2010). Modifications such as slowing the pace of therapy, placing follow-up outreach calls and providing written information may improve the effectiveness of some therapies (American Psychiatric Association 2000) and interventions should focus on age-specific issues such as loss and isolation. Interventions that have been successfully used to treat alcohol problems in older people include brief interventions, family interventions, motivational counseling, cognitive behavioural approaches and group support work (Table 2).

Key Points

- Older people are just as likely to benefit from treatment as younger people.
- Treatment should be person-centered and strengths-based and focus on quality of life issues as well as alcohol use.
- The duration and frequency of treatment should be determined by the client's needs.
- Clients should be given the option of receiving treatment at home.
- Case management and good collaboration and communication are essential.
- Family involvement and peer support can be beneficial.
- Dependent drinkers should be referred for additional evaluation and treatment whereas those who drink above recommended limits but have no complicating factors can be given brief interventions in non-specialist settings.
- Empirically supported treatments in adults are generally suitable for use with older people but they may require modification.
- Brief interventions, family interventions, motivational counseling, cognitive behavioural approaches and group support have been successfully used to treat alcohol problems in older people.

Table 2 Examples of interventions that have been successfully used to treat older people with alcohol problems

Treatment	Example	Evidence of Effectiveness
Brief interventions	Project GOAL, a brief intervention consisting of two 10-15 minute counselling sessions with a doctor in a primary care setting and two follow-up scripted phone calls by clinic staff who provided advice and education (Fleming, Barry et al. 1997).	At 12-month follow-up, Project GOAL was found to yield a significant reduction in weekly alcohol use, episodes of binge drinking and frequency of excessive drinking in comparison with that of control group.
Family work	<p>In a social work case study, Perkins and Tice (1999) describe an 80-year old widow who was an early onset drinker. The social worker worked with the family to gain insight into her drinking, why she relapsed and why she refused their help. Through a process of dialogue and collaboration, the social worker and family influenced her state of readiness to change.</p> <p>In another case study, Haley, (1999) described how a multidisciplinary team consisting of a doctor, psychologist, social worker and nutritionist worked with the daughter of a 72-year-old man during his treatment for alcohol misuse and dementia. She was educated on the medical consequences of alcohol misuse, supervised his medication and dietary regimens and limited his access to alcohol.</p>	Not evaluated.
Motivational counselling	Combined medication and motivational counselling delivered by nurse-practitioner over a 3-month period. Included a biosychosocial evaluation, direct advice to the patient on coping with risky situations and assessment of outcomes and needs over time (Oslin, Pettinati et al. 2002).	Older people had greater medication adherence and attended more therapy sessions resulting in less relapse.
Cognitive behavioural approaches	Gerontology Alcohol Project (GAP) (Dupree and et al. 1984), a day-treatment programme for older drinkers in which both self-management techniques and cognitive behavioural therapy are used. The treatment approach emphasizes self-management, skills acquisition and social support.	At 12 month follow-up, 75% of participants in GAP maintained their drinking reduction goals and increased the size of their social support network.
Group support work.	The GET SMART programme (Schonfeld, Dupree et al. 2000), an outpatient programme for older people with substance misuse problems consisting of 16 weekly group sessions using cognitive behavioural and self-management approaches. Group sessions initially analyse substance use behavior to determine high-risk situations for substance use, followed by a series of modules teaching skills for coping with social pressure, isolation, uncomfortable feelings (such as depression, anxiety, anger and frustration), cues for substance use, urges and slips or relapses.	Of the 49 patients who completed the programme, 55% remained abstinent six months after the programme while an additional 27% were abstinent at the time of follow-up but had experienced at least one 'slip' after completing the programme. Those who completed treatment were significantly more likely to be abstinent than those who did not complete the programme.

Specialist Older Peoples' Services

In recent years there has been a debate as to whether substance misuse treatment agencies should develop services specifically for older people. The United States Department of Health and Human Services (1998) recommends that older people should be 'treated in age-specific settings where feasible'. Specialist older peoples' services have been introduced in substance misuse treatment centres across the US; a recent survey found that 20% of private substance misuse treatment centres offered specialist services for older people (Rothrauff, Abraham et al. 2011) and an earlier study of both public and private treatment centres found that 18% had special older peoples' services (Schultz, Arndt et al. 2003). Accumulating evidence suggests that these older peoples' services may be linked to better treatment outcomes and adherence than mixed-age services (Kofoed, Tolson et al. 1987; Kashner, Rodell et al. 1992; Atkinson 1995; Blow, Walton et al. 2000; Slaymaker and Owen 2008).

However, in the United Kingdom, through our professional networks we have only been able to identify five substance misuse agencies which have an older peoples' service, three of which are in England, one in Northern Ireland and one in Scotland. Based on 2004 data on the number of alcohol services operating in England (Drummond, Oyefeso et al. 2005), this suggests that less than 1% of alcohol services in England provide a service specifically for older people. Even assuming that services exist which we are not aware of, it appears that specialist older people's services in the UK are scarce. We considered if the findings of this study can give any indication as to whether specialist older peoples' services in the UK are more acceptable to older people than mixed age services and/or are delivering additional benefits to inform debate on future service delivery.

The working practices and cultures of mainstream substance misuse services are inevitably geared toward the majority population and it seems unrealistic to expect that practitioners in these services will have the same level of interest and expertise in working with older people as those in specialist services. The four specialist older peoples' alcohol services that we visited during this study were tailored to meet the needs of older people including smaller caseloads, a lengthy and comprehensive assessment process, a slower pace and extended period of treatment, the option of home visits, a high level of multi-agency working and case-management, family and peer involvement and a focus on age-specific issues.

There have been no formal evaluation studies of specialist older peoples' services in the UK therefore it is not clear whether or not treatment outcomes for older people attending these services are better than those for mixed-age services. However, some older people that we interviewed stated that the treatment that they had received in the older peoples' service was superior to treatment they had received previously in mixed-age services:

"I have just finished a one-to-one counselling course a couple of months back and that sort of went on once every three weeks for six or seven months and at the start of the course I was, let's say I certainly wouldn't have been sitting here relaxed talking to you and now I can be. Everything was shut down in my head and now it is not and that for me is a hell of a relief... Once I really settled in it was easy for me to open up and talk about myself. Also the counsellor herself was absolutely fantastic. Over the last four years I have spoken to all sorts of counsellors, doctors whatever, on and on and over four years I have tried to get off it and didn't succeed.... For the first time in my life I can talk about drink without drink talking with me.... For my first time in my life I actually like me. I am content with me. I am comfortable where I am." (Geoff, 67, early-onset)

"Helen has been a constant lighthouse in my recovery. Which is brilliant. I think that is really, really important. I have had therapists and whatever before and I have to say Helen I can really talk to and it is a collaboration. Which I think is really important, there is somebody that listens to me and you look forward to that moment of sanity once a week. It becomes very, very valuable and it is

something that I have trusted. So that has been my one constant through my pretty rough recovery.” [Alan, 61, early-onset]

Our research also suggests that some older people may feel more comfortable disclosing and discussing problems with same-age peers than participating in mixed-aged groups. One practitioner told us:

“When you observe a SMART meeting [for older people], it is the peer support that they are getting, they can relate to others of the same age, estranged from their families, health, isolation. How people perceive you should be. There is all this common ground that they all share, that is particular to that time in their lives.” (Practitioner, Addaction Over 50’s Project, Glasgow)

Mixed age services may be inappropriate if they bring vulnerable older people into conflict with younger clients as Humphrey’s story illustrates:

“The [name of mixed age residential treatment centre] has a lot of frightful yobbos. They gang up against an educated man like me. They loathe my guts. I am just going to have to bear it you know. They have a vocabulary of about 700 words and half of them are expletives.... But I just avoid them. I am allowed to eat out so I get away from them.” [Humphrey, 59, late-onset]

Finally, and perhaps most importantly, the specialist older peoples’ services that we visited invested a considerable amount of resources into raising the profile of the issue, delivering training and ensuring that older drinkers’ interests are considered in local policy.

Therefore, the findings of this study indicate that specialist older peoples’ services may have an important strategic role to play in this area and offer additional benefits in terms of treatment to mainstream services.

Recommendations

These provisional recommendations emerge from synthesis of the literature and opinions of expert practitioners and older drinkers interviewed during this study. However, they have been developed with a view to stimulating discussion amongst stakeholders rather than being prescriptive.

We suggest that health and social care workers should:

- Know what life changes and physical signs/symptoms are associated with problem alcohol use in older people.
- Have a basic understanding of which medical conditions and medications may lead to adverse reactions with alcohol.
- Be able to screen and discuss alcohol use with older people tactfully and sensitively.
- Be able to collect and interpret information on alcohol use (frequency and quantity), drinking consequences and everyday functioning.
- Be able to deliver brief advice tailored to meet the needs of the individual.
- Develop links with alcohol services and know when and where to refer older people who require specialist treatment.

We suggest that mainstream alcohol practitioners should:

- Have a good knowledge of age-associated stressors, precipitating factors and risk factors for relapse.
- Be aware of some of the risks associated with problem alcohol use in old age such as falls, elder abuse and suicide.
- Understand the distinction between early and late onset drinkers and the implications for treatment.
- Be aware of ageist attitudes and myths that surround alcohol misuse and become skilled at challenging them.
- Be skilled in establishing a rapport with older people and carrying out a comprehensive assessment not only of alcohol use but also activities of daily living.
- Have an understanding of the latest research on what works with older drinkers.
- Be able to deliver age-appropriate, person-centered treatment that tackles the client's day-to-day health, social and living needs as well as the alcohol problem.
- Be able to involve family, caregivers and friends in treatment where appropriate.
- Be prepared to deliver treatment at the older person's home.
- Be prepared to facilitate and oversee a package of support as required.
- Know how to refer to specialist older peoples' alcohol services where they exist.
- Develop good collaboration and communication with colleagues that work with older people in frontline health and social care services.
- Ensure that premises are accessible, safe and culturally appropriate for older people.
- Ensure that older people are represented on service user groups.

We suggest that specialist older peoples' alcohol practitioners should:

- Develop regional training programmes for health and social care workers to challenge ageist attitudes/myths and increase their competency in recognising and treating alcohol problems in older people.

- Work with mainstream alcohol services to assist them to deliver assessments and treatments that account for differences unique to older people.
- Develop strong links with social and health care services which are likely to encounter older problem drinkers and prepare clear guidelines and procedures for working with them.
- Make links with local academic institutions that deliver education to social workers, doctors and nurses to ensure that the curriculum includes content on substance misuse amongst older people.
- Develop strategies to identify 'hidden' older problem alcohol users such as raising awareness of the signs and symptoms amongst the general public and practitioners.
- Offer consultation for professionals on older problem drinkers with the most complex needs.
- Develop strong networks with other stakeholders such as older people's organisations, carers support groups, domestic violence services, older peoples' day centres and residential nursing homes.
- Facilitate peer and family support groups.

We suggest that commissioners should:

- Consider commissioning local need assessments in relation to older peoples' drinking.
- Provide support for specialist older peoples' alcohol services, especially where there is a high prevalence of alcohol problems.
- Ensure that targets for services are reflective of the complexity of work with older people.

Concluding Remarks

This study will inform the development of a set of concise, best practice guidelines for health, social care and alcohol workers which we will disseminate in professional magazines and journals, at meetings and conferences and via existing professional networks. It also lays the foundations for a more extensive programme of work which we intend to carry out including:

- Drawing on the experience of experts from fields such as primary care, mental health, social services and substance misuse to develop an action plan to tackle this issue.
- Developing a booklet on sensible drinking in later life for older people, their carers, friends and family.
- Developing a website for professionals, older people, carers, friends and family.
- Establishing a network of professionals with an interest in this area.

The consequences of alcohol misuse amongst older people presents serious challenges for both individuals and society. Considerable research is needed concerning the nature of alcohol misuse in this population and the impact of specific alcohol treatment strategies. We are committed to developing this area of work and would like to thank Alcohol Research UK for funding this study.

“How do I feel now? If I said just hanging off the chandeliers and they won’t fall down because I fixed them.”

Jim, 62, Late-Onset

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