



Older people and alcohol: a report on research in Ayrshire and Arran

Third Sector First

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The views expressed in this report are those of the authors and do not necessarily reflect those of South, North or East Ayrshire Councils, NHS Ayrshire & Arran, or the Alcohol and Drug Action Team.

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INTRODUCTION

Older people and alcohol is an area in which limited work has been carried out and about which little is known. In old age even modest use of alcohol can have a significant impact on health and well being. This is a largely hidden and unacknowledged problem. It remains so in part because of public perception and public policy associating harm - for example, disease, disorder or addiction - with excessive drinking. But most older people do not drink at levels associated with a 'drink problem'; it is just that the physiological and lifestyle changes that come with ageing can reduce tolerance and amplify risk factors.

This study looked at the impact of alcohol on the health and well being of older people living in South West Scotland. The project was commissioned against the backdrop of a growing interest at a national level in the effects of alcohol use and misuse and in the course of the study a major review of licensing laws¹ was completed and published.

Another major driver was the Joint Future Agenda², which provides an imperative to improve the way health and social services in Scotland work together in the provision of community care and older people's services, particularly those enabling older people to remain in their own homes for longer.

The research was commissioned by South Ayrshire Council on behalf of the three Ayrshire local authorities (North, South and East), the NHS Ayrshire & Arran and the Ayrshire & Arran Alcohol and Drug Action Team, in order to clarify the extent to which alcohol contributed to or compromised the health, well being and capacity of older people in their area to live rewarding and independent lives.

The report starts by highlighting the main aims of the project and the method used is then outlined. The results section presents the findings of the research under six main headings: the prevalence of alcohol consumption by older people; the patterns of consumption of alcohol among older people; the reasons why older people drink; the available information relating to alcohol consumption in old age and the impact of alcohol on older people. Five vignettes have been constructed with the aim of synthesizing the findings. The vignettes

¹ Scottish Executive (2003) *The Nicholson Committee: Review of Liquor Licensing Law in Scotland*. Edinburgh: Scottish Executive.

² Scottish Executive (Date unknown) *Joint Future Agenda: What is it?* Edinburgh: Scottish Executive. Available at: www.scotland.gov.uk/about/HD/CCD2/00017673/JFAgenda.pdf Accessed 07/04/04

are summarised at the end of the results section and can be found in detail in Appendix 1 of the report.

The discussion section provides an opportunity to reflect on one of the fundamental messages from the research and upon the problems experienced during the project. In the final section, the project's recommendations for action are detailed along with their evidence base.

The literature review, which comprised an important part of the research, is separately available from the Ayrshire & Arran Alcohol and Drug Action Team (ADAT). To obtain a copy please contact the ADAT on 01294 323 183 or send an email to enquiries@adat.org.uk.

AIMS AND OBJECTIVES

The overall aim of the study was to ascertain the extent of the problem associated with the use and misuse of alcohol by people aged 60 years and older in the three local authority areas (South, North and East Ayrshire). It also sought to provide solutions to assist in the development, commissioning and delivery of services.

The three main objectives were:

to carry out a review of the literature that would provide information on numbers of older people affected by alcohol misuse at a national and local level and to identify some of the problems they face;

to identify the range of, and evidence for, problems arising from alcohol consumption for people in the three study areas; and

to develop a set of evidence-based recommendations for the development, delivery and commissioning of services for older people.

METHODS

There were four main components to the project:

the literature review;

the media campaign;

individual interviews; and

focus group discussions.

The literature review

A review of the literature relating to ageing and alcohol was carried out during the early stages of the project. The purpose was to validate the enquiry by reviewing previous, relevant research and, with reference to previous studies, to understand how much older people tend to drink, the reasons for their drinking and patterns of consumption.

The review was also used to inform the research by placing it within the wider evidence base and Scottish policy context. It provided important information on the levels of drinking in different age groups at a national level, which was then used as the basis for developing a series of predictions of the prevalence of alcohol use at the local level.

The literature review also provided a steer for the qualitative phase, informing the development of research tools including interview schedules and topic guides.

Although it has been updated in light of recent publications, it was not an exhaustive or 'systematic' review. However, it covered the major issues surrounding alcohol and older people and clarified the Scottish Executive's stance on alcohol problems. The literature review is separately available from ADAT. Details of how to contact ADAT can be found in the introduction to this report.

The media campaign

To raise awareness of and recruit respondents for the research the project was promoted through a media campaign, which encompassed the traditional, new, local and national media. With the support and direction of South Ayrshire Council's Communications Manager, the project was featured in the Ayrshire Post and other local papers, the Glasgow Evening News, and on Westsound, the local radio station. Notices were also placed in Community Care magazine, Ageing Matters (the RCN newsletter), Signposts (the Age Concern newsletter) and on email notices to members of the British Society for Gerontology and the Social Work Alliance.

In addition to the traditional media, pages on Third Sector First's website were dedicated to the project, providing information and points of contact. Briefings were also posted on the ADAT, South Ayrshire Council and North Ayrshire Council websites, and links set up between these and the interactive project pages on the Third Sector First site.

Local newsletters were also used to inform the local communities and these included the Loch-al-news, Muirkirk Community News and Maybole Community News. Information about the project was also provided to local churches and voluntary organisations known to issue newsletters or have the capacity to display leaflets or posters.

Information sheets and posters were also sent to NHS staff and sites, generating a small number of responses.

Individual interviews

Individual interviews were conducted with health, social care, local authority and voluntary / not-for-profit sector professionals. Through representative groups and social organisations, older people across Ayrshire and Arran were also contacted. All but one individual interview was semi-structured and tape-recorded.

Interviews with professionals

Using a snowballing technique, 17 health and social care professionals were contacted and interviewed. They were predominantly from South Ayrshire. The interviews were either conducted face to face or by telephone. As well as generating important research material a number of professionals extended invitations to participate in the study to the older people with whom they worked.

In addition to the interviews carried out with statutory sector professionals, contact was also made with voluntary and not-for-profit organisations. They included social housing providers, health associations, support groups and carers' centres, churches and the major older people's charities spread across the three LA areas. In total, five in-depth interviews were conducted with voluntary sector representatives, of which four were face-to-face and one was by telephone. Due to their expressed working interest in the research area, an additional interview was conducted with a senior voluntary sector representative operating outside the LA areas.

Interviews with older people

In order to maximise awareness of the project among older people in the study areas, contact was made with older people's forum groups and older people's social organisations. Help the Aged facilitated access to the West of Scotland Senior's Forum, which circulated information about the study to the Ayrshire forums. In addition, contact was made with

forums in South Ayrshire via South Ayrshire council. The response generated by these approaches was disappointing and this, as well as other problems faced during the fieldwork, is described in the 'discussion'.

Ultimately only a very small number of individual interviews were conducted with older people who were affected by the misuse of alcohol by close family members. The majority of fieldwork material from older people was generated through the group discussions, or 'focus groups'.

Focus group discussions

In order to set up focus group discussions, further older people's organisations were contacted via Age Concern Scotland and the local Councils for Voluntary Organisations / Services. Six focus groups were conducted; five in South Ayrshire and one in North Ayrshire. Most of the discussions were tape-recorded and field notes were made during and immediately following the sessions.

RESULTS

The results of the study are presented below under six main headings:

Prevalence;
Patterns of consumption;
Reasons for drinking;
Available information;
The impact of alcohol consumption on older people; and
Five vignettes.

Prevalence

Evidence from the data

There is little solid information on either the numbers of older people who consume alcohol or on the amounts that are drunk by them in Scotland or other parts of the UK. Therefore this study set out to look at the limited national information and to verify whether this matched the perceptions of professionals, older people and other interested parties in

Ayrshire. Using national data, likely prevalence figures for older people in Ayrshire with alcohol problems have been produced. It should be noted that the numbers are calculated by projecting drinking patterns for all older people from information, for example, on those aged 65 to 74. It is also important to emphasise that the figures are based on taking the current safe weekly limits of alcohol consumption for adults (14 units for women and 21 for men) and continuing these into old age. There is clear evidence that safe limits for older people should be lower than for younger adults and the implications of this will be discussed further in the report.

With the provisos outlined above, it was calculated that from between 3,757 and 6,923 older people in Ayrshire were drinking above safe levels; that is between 6% and 11.05% of the total population of 62,620 people aged over 65. One source suggested that four times as many men as women would have alcohol problems³, another that there would be twice⁴ as many men as women.

Figure 1 (APPENDIX 2) shows the projected number of older people, men and women separately, in Ayrshire with alcohol problems by each of the three local authority areas.

Figures 2, 3 and 4 (APPENDIX 2) show approximations of the urban/ rural split in the three areas according to three different data sources (GHS, 1996; Wood and Bain, 2001 and HEPS, 2002⁵). To calculate these figures, each ward was ascribed a rural or urban base and the figures were then accumulated to give the total picture. The significance of treating the urban and rural situations separately will be highlighted later in the report.

It is important to reiterate that the figures in each table should be treated with caution. Due to the paucity of available data they are indicative rather than certain projections, but they do portray a picture of trends and differences, which have relevance for understanding the nature of alcohol problems and the provision of services. In the 'recommendations' section of the report there are suggestions for ways in which a more accurate local picture could be developed.

³ Wood, R. & Bain, M. (2001) *The Health and Well-being of Older people in Scotland: Insights from national data*. Edinburgh: Information and Statistics Division, Common Services Agency for NHS Scotland.

⁴ OPCS, Social Survey Division (1996) *Living in Britain: Results from the 1994 General Household Survey*. London: HMSO.

⁵ Health Education Board for Scotland (2002) *Health Education Population Survey*. Edinburgh: Health Education Board for Scotland (HEBS).

Evidence from the interviews

The majority of the respondents believed that there is significant underreporting of alcohol consumption and that any 'official' data would therefore underestimate actual prevalence levels. In addition, most people think the focus is on those with severe problems, not on moderate and light drinkers, so the reporting of alcohol problems in old age would only occur where there are high levels of consumption.

A number of the professionals that were interviewed suggested that another reason alcohol problems are underreported is that they are usually cited as medical problems. So, for example, they might be recorded as a liver condition rather than any connection with alcohol consumption being made. Similarly one interviewee commented that in medicine 'the consequences of alcohol misuse are confused with non-specific states and conditions often linked to the ageing process'. One of the vignettes outlined at the end of the results section illustrates how health professionals and lay people are often uncertain whether the behaviour and symptoms that they see are the consequence of illness or disability, or whether alcohol consumption has contributed to the condition.

One of the local authority professionals supported the view that national data could not be trusted and this was specifically in relation to the variations of consumption and reporting in rural versus urban areas. They suggested that isolated rural communities have markedly different patterns and rates of alcohol consumption and that, crucially, the reporting in rural areas differs because it is very difficult to keep the problem secret. In the small rural areas there is little privacy and little scope to hide problems of alcohol misuse in the way they can be hidden in less personal urban communities.

As well as suspicions about official data on alcohol consumption and about levels of accurate reporting among professionals, there was also a lot of scepticism about the reporting of alcohol problems by older people themselves. In particular, respondents described how older people will fail to record drinks perceived as 'medicinal' and how older people, like the rest of the population, associate alcohol problems with extreme levels of consumption that they do not relate to themselves. At the crux of this issue is a critical problem about the confusion and lack of information available to older people about safe levels of drinking. This problem will be further explored under in the section headed 'available information'.

Patterns of consumption

The literature review highlighted the importance of exploring the patterns of consumption of alcohol by older people. Therefore, the fieldwork sought to understand when people drink and how this fits in with the pattern of their day, whether they drink alone or with others, and where they drink, for example at home or in the pub. It also explored the changing patterns of consumption in old age, for example, whether there is less drinking in pubs, or whether there is less heavy drinking in any one episode but more solitary drinking, which may start earlier in the day.

Overall, the respondents, both professionals and older people, felt people drink more at home as they age because of the greater difficulties of getting out, fears about safety of being out at night, and the fact that it is far easier to buy alcohol to drink at home than it used to be.

There seemed to be agreement that there exists a gendered pattern of drinking. At one seniors' club the women reported that older men were most likely to go to the pub in the afternoon, because of concerns around personal safety - although this may have reflected their wives' and partners' concerns rather than their (the older men's) own. One respondent said that her husband, now in his 80s, does go to the pub at night-time and insists on walking home. Although a great worry to her, she recognised that this is important to him and his sense of independence. A man in Largs said that he did not visit the pub very often because there is no pub near to his home and no buses into town after 5 pm.

One woman in Largs described her own strict routine in terms of alcohol consumption. With a friend, she goes to a pub once a week where they have two drinks of whisky with water and that is the only time she touches alcohol. She clearly demarcated the time and place she drinks: only once a week and only outside the home. This contrasts with another female respondent, who enjoys a glass of wine only at home, with her dinner. Although these two differing approaches seemed to reflect personal codes about alcohol consumption, in smaller towns where there is only a single pub, or no pub at all, decisions about where to drink are likely to be limited by the practicalities of access.

Many of the professionals that were interviewed felt that the pattern of older people's daily lives is a significant framework for their consumption of alcohol. A distinct feature of the daily routine for many older people is the lack of an externally imposed routine. For some people, the consequence is that they find it hard to structure their own day. Those who

have found it hard to create a satisfactory structure to their day may feel lonely or depressed. These were thought to be two significant factors that would lead people to drink. Many people manage their own drinking behaviour by what are in effect internal guidelines such as, 'I don't drink before supper' or 'I don't drink during the working day'. However, when people drink because they feel low they are likely to do so in response to the situation rather than the time of day. Thus some will add a drop of whisky to their morning tea because they have had a bad night, and others may do the same at night-time because they do not look forward to going to sleep.

Of course a small tot once per day may have little impact. The point, which is reiterated throughout this report is that there is no research knowledge that highlights the impact of low levels of alcohol on people's management of their day and that people themselves may not have considered the possibility that their low levels of drinking may lead to problems for them. Drinking at night is likely to affect people's sleep rhythms and increase night-time visits to the bathroom. Drinking in the morning is likely to make people less active and may lead to them not being bothered to get themselves a meal.

One respondent, a home care manager, emphasised the importance of trying to build in structure to the resident's day, especially where people are isolated. However, she noted that it is imperative to achieve a balance and not impose one's own values. She also reflected on the importance of promoting the self worth that many older people feel that they have lost and ensuring they maintain control over their daily lives.

The manager of a service for homeless people made a similar point. In an attempt to help people establish some structure in their day he has recently opened a breakfast club for his homeless service users, encouraging them to get up before 10.00am. However, he emphasized that to do that, other services and facilities need to be made available during the day. This issue also relates specifically to older people who use or misuse alcohol. If structure in people's days is to be encouraged where it may be lacking, and if alcohol consumption is to be discouraged, then alternative activities or stimuli must be introduced.

Reasons for drinking

A range of explanations for drinking alcohol is described in the literature. Three particular motivations were to build confidence, to socialise, and to cope with adverse events and feelings. These factors may result in increased alcohol consumption at any stage in the life cycle but there are some stressors which are particularly common and powerful in older age, for example, boredom, isolation, fear and ill health. Indeed, many of our respondents

agreed that where people do not know how to address loneliness they may turn to alcohol for comfort and refuge.

Isolation associated with one's own increasing fragility and lack of mobility is probably compounded in Ayrshire by the disparate nature of communities. Older people in Ballantrae, for example, are 36 miles from the hospital in Ayr and 13 miles from the nearest residential home. We were told that this small community is not served by any form of public transport, though BRICC (Ballantrae Rural Initiative Care in the Community) co-ordinates a volunteer transport service which will take people to the hospital, or to a GP appointment for a nominal charge. One respondent observed that in rural communities there were many older, unmarried, women who had cared for their parents for many years and then on their death were left entirely alone.

Voluntary sector respondents identified loneliness, related perhaps to boredom and isolation, as an important factor behind alcohol consumption. This led to the case being presented not just for more social clubs, but also to cater better for men's interests and to address the lack of transport in rural South Ayrshire.

During one of the discussion groups, participants suggested some older people who are lonely use alcohol consumption as a way of filling their otherwise empty days. One person described the case of a local woman whose husband had been killed in an accident in a coal pit. The trauma and subsequent loneliness led to her turning to alcohol, which eventually caused her own death. Reflecting on this one participant mused, 'truly alcohol can kill'. Some of the other participants felt that where people use alcohol to control loneliness or isolation, their whole lives in turn become controlled by alcohol, 'Alcohol controls you if you don't control the alcohol' and, 'Instead of being the servant alcohol becomes the master'.

Available information

Perhaps the most alarming findings, and those providing the greatest challenge for policy makers and service providers, are those relating to currently available information about alcohol, especially in relation to older people. The research findings fall within two main themes; a lack of information and the existence of confusing information, or 'mixed messages'.

A lack of information

The respondents, both professionals and older people were very well aware of the existence and effects of problems associated with 'heavy end' consumption of alcohol. However, that is where their shared understanding seemed to end. Those interviewed seemed readily to acknowledge the problems associated with alcoholism, but there was little, if any, awareness of the hazards of moderate drinking in older age, except insofar as care is needed with regard to drinking and driving.

Throughout discussion groups and interviews, people persistently reverted to talking about alcoholics and this tendency supports the need outlined under 'recommendations' for a specific definition of what constitutes moderate drinking as compared with alcoholism.

The older people consulted in discussion groups tended to associate alcohol use in old age as being something associated with other people's lives rather than being a feature of their own. When asked to consider their own drinking habits, individuals' views and attitudes did seem to indicate a lack of knowledge of the potential impact of drinking even small amounts of alcohol. People who would be appalled at alcoholism, and at alcohol leading to violence and annoyance for neighbours, may nevertheless not appreciate the effect on their own lives of even moderate or low levels of consumption. Some professionals working with older people felt that alcohol, consumed even at these lower levels, has been a key influence in an older person needing the support of domiciliary services or even in having to move into a residential or nursing home. They maintained that it is probable that older people themselves will not have been aware of the impact and ultimate consequence of their drinking.

Mixed messages

Where knowledge about alcohol did exist it was often confused by the mixed messages people receive. Among those who participated in the discussion groups, the confusion was mostly related to the supposed health benefits of alcohol consumption. Drinking, especially spirits, was often linked to increased longevity and in some cases to the treatment of certain ailments.

For example, someone who lived to the age of one hundred was reported as saying that a bowl of porridge in the morning and a whisky at night was the secret of her longevity. Therefore, people were inclined to say: 'If it's good enough for that person it's good enough

for me'. Another person was told by a GP that whisky thins the blood and so started to drink when previously they had not.

Another discussion group member at a senior citizens' club similarly described how her 105 year old cousin had taken a dessertspoon of a spirit in tea both morning and evening and that her doctor had attributed her longevity to this. Similarly the respondent's parents had taken a so-called 'medicinal' drink in their tea, believing this to be beneficial.

It was clear that these reported patterns of alcohol consumption - whether a 'tot' last thing at night or with one's morning tea - were not perceived by older people as drinking *per se*. A number of club members participating in the focus groups at first stated that they were non-drinkers; however, as the discussion developed, they conceded that they did drink occasionally, with whisky or brandy being their drink of choice.

The mixed messages that respondents have received appear to have further confused the issue over 'safe levels' of drinking. The fieldwork showed that there is only limited understanding of what are set as safe levels for the population as a whole, and even less of safe levels in older age.

The lack of adequate information also seems to have compounded the problem around people recognising and dealing with their own excessive alcohol intake. Those who drink to help them sleep at night or 'get going' in the morning did not consider themselves as 'drinkers'. This, combined with the fact that the term 'drinker' may well be seen as pejorative, meant that people were anxious to define themselves as non-drinkers and in doing so distance themselves from any possible problems. Many of the professionals and some older people themselves agreed that 'mixed' messages about alcohol intake are at best unhelpful and can at worst be dangerous.

The impact of alcohol consumption on older people

The literature review⁶ quotes from a Royal College of Physicians' statement cited on the Alcohol Focus Scotland website that 'as many as 60% of elderly people admitted to hospital

⁶ Clough, R. & Hart, R. (2004) *Older people and alcohol. Background paper – a review of the literature*. Newchurch: Third Sector First.

because of confusion, repeated falls, recurrent chest infections and heart failure, may have unrecognised alcohol problems⁷.

There are other conditions in old age that are likely to be worsened by alcohol consumption and these include self neglect, incontinence, poor sleep and medication problems - for example, muddles in taking medication and adverse reaction between drugs and alcohol. Such conditions may mistakenly be regarded by both family members and health professionals as simply signs of ageing and the impact of the alcohol may be masked or ignored, as may the likelihood that these conditions are treatable.

One of the consistent themes in this study has been the frequency with which professionals working with older people have stated that they think alcohol plays a far bigger part in the problems that older people face than has been recognised. Where some were already aware of this, other professionals in Ayrshire were surprised that they had not thought before about the potentially harmful influence of alcohol on the lives and health of older people. The recommendations section of this report addresses the steps that could be taken to produce firmer evidence of the impact of alcohol on older people's lives.

The remainder of the results section highlights the findings from three aspects of the research: the literature review, the individual interviews and the group discussions. Material derived from those three elements of the study support the assertion that there is a far greater impact on older people's lives by alcohol than has been recognised. The problems that are focussed on are falls, daily living, incontinence, medication and crime.

Falls

Compared with the rest of the population, older people are most likely to experience falls, and injuries and fatalities following falls. Trying to reduce falls has been one of the central thrusts of primary and social care. In their review of interventions in falls, Easterbrook *et al* (2001)⁸ highlighted the evidence behind this policy drive. For example, hip fractures, which for older people, are one of the main consequences of falling cost the NHS in the region of £12,000 per patient. Moreover, hip fractures and other falls injuries are major factors leading to premature admission to long-term care whether permanent residential care,

⁷ Alcohol Focus Scotland (2002) *Older people and alcohol*. Available from www.alcohol-focus-scotland.org.uk/aboutalcohol/people/old/problems.asp. Accessed 29/07/03.

⁸ Easterbrook L., Horton K., Arber S. & Davidson K. (2001) *International Review of Interventions in Falls among Older People*. London: Department of Trade and Industry.

hospital or social care at home. Easterbrook *et al* point out that even where physical injuries appear to be minor, individuals can lose their self-confidence. If in consequence the older person reduces the activities they carry out, their independence can be compromised and more support services may be needed at an earlier stage.

Although research exists that highlights the part played by alcohol in causing falls (Hill et al, 2000)⁹ little mention is made of reviewing alcohol consumption in the drive to reduce falls among older people. The National Service Framework for Older People¹⁰, which includes a strategy to reduce falls, largely disregards the contribution made to their occurrence by alcohol.

These gaps in advice and information persist despite a number of studies of accident and emergency admissions (A&E) that highlight the frequency with which alcohol is mentioned as a factor in accidents. For example, McDonach *et al*¹¹ carried out a pilot study in Scotland to investigate the extent to which alcohol can be linked to accidents among older people by examining the reasons why older people attend A&E. They studied patients aged 65 and over attending one A&E department during a two-week period and found that from their 73 respondents:

falls were the most common reason for attendance;
two thirds of patients reported drinking alcohol;
12 patients drank at least twice a week;
11 patients drank four plus times per week;
8 of the patients attending due to a fall reported drinking alcohol at least twice a week; and
1 person was at risk from potentially hazardous drinking.

In the light of this and other research it is surprising that the issue of alcohol is still absent from strategies for tackling falls. It illustrates one of our key recommendations, which is developed later.

⁹ Hill L.D., Haslam R.A., Howarth P.A., Brooke-Wavell K. & Sloane, J.E. (2000) *Safety of older people on stairs: behavioural factors*. Loughborough: Loughborough University.

¹⁰ Department of Health (2001) *National Service Framework for Older People*. London: Department of Health.

¹¹ McDonach, E., Bell, K., Gallacher, D., & Gilhooly, M. (Date unknown) *Accidents and attendance at A&E: the role of alcohol and polypharmacy in accidents amongst older people*. Paisley: Centre of Gerontology and Health Studies.

Consideration of problems arising from alcohol consumption by older people must not be seen solely as of relevance to alcohol services. Actions on many of the key target areas for older people's services, like falls prevention, must incorporate action on alcohol consumption. There is no point in encouraging people to wear sensible footwear, light the stairs and put up better support rails if older people are also not advised to review their alcohol consumption. Given the serious impact of falls on people's lives it is a neglect of responsibility not to ensure that older people are confronted with the reality of their circumstances.

The review of the literature and the feedback from professionals suggests that the prime significance of alcohol for older people's safety is that it may make a difficult situation more problematic, rather than being a problem in its own right. Typically it is not that alcohol in itself creates the problem, causing someone otherwise steady on his or her feet to fall over; the more common impact is likely to be in situations where someone finds mobility difficult, or where there are features of the environment that are awkward. It is in these circumstances that alcohol can act to increase the likelihood of a fall.

Medication

Our research found less evidence of the impact of alcohol on other aspects of daily living and safety. However, there is no doubt that there is a lot of concern both from older people and professionals as to the consequences for older people of the interaction of alcohol with medication. The professionals that were interviewed pointed out that the issue is complicated because of the use of drugs bought over the counter. In addition to the interaction of prescribed drugs with alcohol, the mix of self and GP-prescribed drugs may have unanticipated effects.

Reflecting the mixed messages that have already been explored, the older people that were consulted held conflicting views. When asked whether they believed their health and well being could be affected by alcohol, there were general murmurs of agreement that they could, for good or bad. For instance, some participants agreed that a sherry could be a useful appetizer. By contrast, if a person tended to be forgetful others thought alcohol might aggravate the problem, particularly as regards taking medication. This was a specific concern as it was thought probable that a higher proportion of older (than younger) people are on medication. People felt that these problems are compounded for individuals with mental health problems who might not take their medication because of forgetfulness induced by alcohol.

Although the people that were consulted had an awareness of the problems caused by combining alcohol and medication, they believed that the interaction of alcohol and medication is not well understood by older people. They reported that the issue is not adequately explained by doctors, who may write prescriptions but fail to ask about alcohol use or abuse.

The concerns described by discussion group participants were reflected in findings from the McDonach study¹² which found that whilst 6 out of the 45 people who reported drinking alcohol said they would stop taking their medication if they planned to have a drink – in itself a response with potentially harmful consequences - the majority of those surveyed would drink alcohol and take medication simultaneously.

Daily living

Less concern is expressed about the impact of alcohol consumption on other aspects of daily living. As discussed earlier, several respondents thought that the lack of structure to a person's day could influence their alcohol intake. However, our research suggests it is probable that there is also a reverse effect: drinking alcohol affects some people's capacity to structure their day. Thus, drinking during the day will impact on how people manage their lives: it may make people more soporific, less likely to eat properly or take exercise and, of course, alcohol has a depressive effect. Drinking at night-time will affect the quality of sleep and may result in waking earlier. Some of the interviewees, both professionals and older people, also suggested that drinking alcohol might lead people to be less concerned about looking after themselves.

Several respondents voiced concern that drinking would compound existing problems. For example, where people drink alone because they are isolated, such drinking will result in far greater isolation if people have, as a consequence of drinking, less enthusiasm to go out. Incontinence is another problem that faces some older people and it is clear that alcohol consumption is likely to make this problem worse.

Other respondents mentioned concerns over potential problems with fires and other accidents. However, there is a caveat to such concerns: neither our literature review nor our consultations with professionals found any evidence of the frequency with which alcohol consumption has played a part in older people having accidents arising from fires.

¹² *ibid*

Crime and victims of crime

Our review of the literature found other studies in which people report that alcohol consumption heightens the risk of abuse, becoming the victim of crime and experiencing problems with tenancies. Respondents also made reference to these sorts of problems. In terms of abuse the risk is heightened in two ways. First, the person committing the assaults is more likely to do so following the drinking of alcohol and in this respect such assaults mirror the impact of alcohol on any other violent assault.

Secondly, the victim may be more likely to be assaulted following consumption of alcohol. Indeed, it is claimed that people are more vulnerable to assaults and burglaries, for example from hoax callers, when they have been drinking. It is also clear that some people, probably a very small number, get into problems with their landlords because of their alcohol consumption. In South Ayrshire it was reported that around two or three people per year fell into this category. Although this is a very small number of people, the experience of the professionals that were interviewed does suggest that alcohol exacerbates the vulnerability of older people.

Five vignettes

The results described here draw on the experiences and reflections of a large number of older people and professionals in relation to alcohol consumption in old age. One of the persistent themes of the study has been people's tendency to revert to notions of alcoholism. Most people only thought of alcohol as being problematic where people were clearly dependent on it, or where occasional excess could lead to an accident or injury. To illustrate the reality of the situation and to draw together the results described above, a series of vignettes have been constructed that seem to characterise common features of alcohol use. In particular, they illustrate the progressive impact of alcohol use in old age, and the social contexts in which drinking might be encouraged, tolerated, ignored or penalised.

The examples which are detailed in Appendix 1 and summarized below are real and they are drawn from the research; the only changes that been made are ones necessary to protect the identity of respondents. Several stories or individual experiences have been synthesized in the vignettes, not to make the examples 'worse' or 'better' than they would otherwise have been, but to try and capture the full range, variety and significance of broadly common experiences referred to throughout the report and especially during this results section.

The first 'type' would be characterised by older people who drank rarely and even then only lightly, but for whom an occasional drink might compromise their medication or precipitate a fall. The second type would be older people whose drinking habits were moderate, predictable and relatively unchanged from early adult life; these might be people whose drinking pattern was unaffected by age, and who would be unaware of the effect that age and changing physiology had on their body's ability to assimilate alcohol. The third type would be the regular and/or heavy drinker, though not one who was necessarily known to the health services or whose behaviour was acknowledged or challenged. The fourth group would be the late-onset heavy drinker, someone whose pattern of drinking had changed in old age, perhaps because of a life-altering experience like retirement or bereavement. Members of this group might be quite severely alcohol-impaired, though this would have been a relatively recent occurrence. The fifth and last group would be characterised as the extreme problem drinkers, people who had moved into old age with a high level of pre-existing alcohol dependence.

The detail of the circumstances described above can be found in the individual vignettes in Appendix 1 of this report.

DISCUSSION

This section of the report provides an opportunity for reflection on two important areas. The first part addresses the fundamental issue of people's attitudes toward older people and alcohol and the second considers the problems experienced during this study. We will comment on how the two matters are linked.

Attitudes towards older people and alcohol

An overriding theme surrounding attitudes towards older people and alcohol was that only 'heavy end' consumption is problematic. The extent to which alcohol consumption affects the daily living of people who might be described as 'moderate' or 'light' drinkers is far less appreciated, probably because it is far less clear. There is no doubt that alcohol has a far greater impact on the body and mind as people age; some individuals may have recognised this for themselves, and reduced their alcohol consumption accordingly. Official guidance does state that what are regarded as safe levels of drinking for adults have to be lowered as people age. However, there is no statement of what this means, although some would say that existing safe levels should be halved. Advice in the USA that does address the effect of alcohol on older people suggests that they should limit themselves to one unit of alcohol

per day. The problem in setting a safe level appears to be that individual variables such as weight, sex, age and body fat make it very difficult to suggest what is a safe level.

Our work suggests that the most significant problem in Ayrshire that has to be considered is not that of the very heavy drinkers. As outlined in the results section, older people themselves identified heavy drinkers as the problem area that needed attention. However, this is in part seemed like a defence to differentiate oneself and one's family from consideration of the topic: it is to be seen as a problem that exists for others. That said, it should be noted that the development of services for heavy drinkers is not ignored in the final section where we set out our recommendations.

Our central point is that, far more than is recognised, older people who are moderate or light consumers of alcohol have their lives adversely affected by alcohol consumption. Currently the data is not collated in such a way as to quantify the extent of the problem for light and moderate drinkers. In the final section we make some suggestions of ways of overcoming this problem. Nevertheless, the extent to which the professionals that were consulted thought alcohol did impact on numbers of people whom they met reinforces the points that are raised in the literature.

Alcohol may affect people's daily living, even though it may not be so obvious in terms of the impact on health: people may be more likely to have falls, be forgetful or confused, have their sleep patterns changed or become incontinent.

It should also be noted that other people's drinking can have a serious impact on older people's lives and so, like the rest of the population, they need informal and formal support to address this. Such support becomes more important when people are isolated, have a diminishing social support network, or are physically and financially dependent on the drinker(s). One professional described the situation of an 82-year-old man with Alzheimer's disease who was living at home with his children who are all heavy drinkers. The interviewee suspected that the so-called carers keep him there for financial reasons, and thought it far from clear that living with them was in his best interests.

The concentration on 'heavy end' drinkers described earlier had a big impact on the attitudes of older people toward alcohol in old age. The overriding theme was that the problem is with heavy consumption and as older people do not heavily consume alcohol there is barely a problem to speak of. Attitudes like these, which also existed among professionals, have obvious implications for tackling alcohol-related problems among older people.

Indeed, the majority of the older people who were consulted did not think alcohol caused much of a problem for older people. Their responses to the issue can be grouped under the following three headings: 'there is little or no problem', 'there is a small problem' and 'there is a very serious problem'.

'There is little or no problem'

Many older people felt the focus of the research was misguided. They thought that instead the project should focus upon young people who drink heavily and make a nuisance of themselves. One of their greatest concerns was the crime fuelled by alcohol and they pointed out that older people are not involved in this.

Indeed, this association between alcohol and crime plays a big part in older people's drinking being given less attention than that of younger people. In terms of scale and visibility it is true that older people's drinking has less impact on other members of the community than does drinking by younger people. In one discussion group, members talked about someone who was known to be a drinker, but it was believed that he did not cause problems for anyone else. This contrasts with the widely prevalent disorder associated with heavy alcohol consumption by young people.

Other people felt there was no issue, simply because older people do not drink. Many claimed to be teetotal themselves and thought the issue of alcohol consumption would be more a matter for the next generation of older people. Whereas one or two respondents resorted to the concept of alcoholism and thought there existed a small number of alcoholics, the majority of those consulted believed that a problem did not exist.

'There is a small problem'

A minority of those consulted conceded that a small problem in terms of alcohol and old age exists; their concern being centred mainly on the interaction of medication and alcohol. However during one discussion group a participant recognised that moderate alcohol consumption could have implications for health beyond the medication issue, although she struggled to find examples or instances where this had been the case.

'There is a very serious problem'

A small number of people described powerful and often harrowing stories of the impact an older relative's drinking had had on their lives. It seemed that people who had faced huge problems over a number of years had often felt let down by service providers and they wanted to explore this during discussions.

Professionals' attitudes to alcohol and old age

In the same way that older people's attitudes to alcohol and old age fall into defined groupings, so too do the attitudes of professionals working with older people. However, the way professionals perceive the issue has a big impact upon the way that they approach instances of alcohol use or misuse and ultimately how effectively the problem is dealt with.

Among the professionals that were consulted there were four general approaches. The first was the group which recognised the potential problem when it arose, but made no mention of it to the older person. This situation is highlighted in the 5th vignette detailed in Appendix 1.

Others were caught between people's rights to privacy and their wish to discuss what they saw as a potential problem. The question of what to say and how to say it seemed to be made more difficult because the relationship between alcohol consumption and daily living problems is not clear cut.

A third group of staff worked under clear directions from their management, were explicit with older people with whom they worked and knew the action they should take. This situation exists for home care staff in South Ayrshire and it was described by one manager:

'When home care workers have concerns about someone's alcohol intake they are told that they must inform their line manager. They are to alert the manager at the point where alcohol is having an adverse affect. They have to distinguish from the person's behaviour between, say, becoming aggressive, and brandy in the tea being no problem.'

However, the most common position was among professionals who had not previously thought that alcohol might be causing problems. On reflection they felt that alcohol frequently affected people's lifestyles. A comment by one professional reflects this position:

'It seems strange, now you mention it, that we have not thought about this before. When you talk about people having falls, not eating properly or getting confused, I can think of several people for whom alcohol might be a factor.'

Those professionals who worked with people who were heavily dependent of course knew of the havoc that was created in those people's lives.

A further feature of perceptions of drinking in old age seems to permeate the attitudes of professionals and lay people alike. The crux of this attitude is to see drinking as one of older people's few pleasures. In part this attitude recognises the reality of ageing for some people where life has become more problematic: there are more struggles because of poor health, money may be tight and people may become isolated. However, the other element of this attitude is an assumption that older people are bound to have a less interesting life and should be encouraged in their 'little pleasures'.

As with many stereotypes there is a measure of truth in such views, as many older people do find that their lives are restricted. Nevertheless, this stance seems patronising. One interviewee, a professional, pointed out that older people are short of things to do for a treat and for some, alcohol becomes a treat in itself. As activities that provide treats diminish in old age, alcohol becomes more dominant and the challenge she raised for service providers was to present opportunities for other treats away from an isolated home or the local pub.

The changing culture of alcohol

The reaction to the topic by older people, professionals and lay people seems influenced by the uncertainty that surrounds alcohol. The changing history of attitudes to alcohol consumption provides an important context that still influences many people either directly in their drinking behaviour or indirectly in how they want to present themselves to the world. This is particularly the case for the current generation of older people. It is not so long since people held very firm views about alcohol, with certain groups viewing drinking as pernicious; determining to abstain themselves and to try to 'save' others from the consequences of drinking.

But for other people, drinking alcohol has always been part of their everyday lives, whether in the pub or, more particularly in higher socio-economic groups, on a regular basis with meals. There were gendered attitudes toward drinking; many thought either that women should not drink alcohol, or, more commonly, should not be seen to drink in public places. A

group of women at a seniors' club reported that they were not accustomed to drinking because when they were younger alcohol was expensive, more difficult to procure, and the presence of women in pubs was frowned upon.

The women in one seniors' group considered that men were far more likely to have developed drinking habits in their youth. They did consider there to be a culture of heavy drinking, which they linked to deep mining and heavy industry.

One of the big practical changes that has arisen out of the shifting culture surrounding alcohol has been the increase in places where alcohol can be bought. One interviewee pointed out the implications for older people for whom alcohol has never been so readily available. She described how in rural communities older people now try and buy their alcohol with shopping, as there is frequently an off-licence section in small shops. She doubts there is much training for off-licence staff and consequently little awareness of the problem of older people buying even moderate amounts of alcohol. Although she felt information should be made available to licensees for training she conceded there would have to be an incentive for them. Furthermore, in small rural communities, off-licence staff may well see older people buying alcohol more as their friends and would therefore find it very difficult to raise concerns about their drinking, worrying that it might demean the older person to question their purchases.

The uncertainty described by this respondent about how to deal at a local level with older people who are using or misusing alcohol reflects the dilemmas faced at a societal level. This study suggests that attitudes to alcohol are marked by two key factors: first ambiguity and uncertainty as to the amount of alcohol consumption that is healthy and, secondly, a measure of secrecy and denial about one's own and one's friends and family members' drinking habits.

It is impossible to know whether people would make different lifestyle choices if they had better information, but it is proper to recognise that an important aspect in decision-making is knowledge – and to recognise that many older people may not be aware of the possible impact of alcohol on their lives. The uncertain status of alcohol itself, compounded by the uncertainty of how to respond to older people, may lead to nobody letting an older person know that their drinking may be having a far bigger impact on their lives than they realise. It is as proper in old age as at any other age to be treated as a responsible person who needs knowledge to make informed decisions; there is a message in this for family members and those working with older people and it will be addressed in the section titled 'recommendations'.

Problems experienced during the research

The research incorporated a media campaign to raise awareness of the issue of alcohol and ageing and to generate interest from potential interview and focus group participants. The process of the campaign is described in the methods section of this report.

Media activities were extensive and awareness of the project should have been widespread. However, in the event, the study did not seem to be well known across Ayrshire. Even within the commissioning organisations awareness of the project was patchy. Although a handful of calls and letters were received in response to features in local papers, there were significantly fewer than the target.

Although publicising the study in the local media generated a very limited number of contacts within Ayrshire, the references in professional journals and newsletters resulted in requests for information and expressions of interest from individuals working across the UK.

Letters were also sent to twenty-four Community Councils in South Ayrshire, as it was believed that as these Councils had local licensing powers and that councillors might be able to provide interesting information on their local community. Only one reply was received.

The limited response received from older people's groups was also disappointing though as the fieldwork progressed it became clear that the lack of interest shown by older people was significant in itself. We suspect that the recurrent focus on the extremes of alcohol consumption may have caused many moderate drinkers to distance themselves from the study, in a concern to disassociate themselves from the stigma of 'alcoholism'.

The recruitment problems that were experienced were not simply a consequence of cultural issues around the subject matter. Due to the nature of the research, ethical approval was sought from both the Local Research Ethics Committee and the NHS Research and Development Committee. The process was time consuming and impacted the project's timetabling, causing a four month delay to the fieldwork.

The planned six months of fieldwork were compressed into two months – this served to compound other issues around recruitment and access. With the older respondents there were issues around ill health, confusion and admissions to hospital or long-term residential care, whilst for a number of interested but busy and overstretched public, health and

voluntary sector staff, it was just not possible to schedule a meeting within the time available.

However the fundamental theme that links the findings of the research with the problems faced in the study is the unwillingness to talk about alcohol use and misuse. It is a very significant feature of the research that people were evidently reluctant to openly engage with the subject of alcohol consumption especially in relation to old age. This aspect has been explored throughout the report and will be a necessary consideration for the recommendations that are made in the next section.

RECOMMENDATIONS

This section sets out our views of the priorities for service development, together with specific proposals of actions that could be taken to implement the priorities. One of the study's main aims was to form a practical strategy couched both in the context of the research findings and in the local context of Ayrshire.

The proposals are recommendations about how services in Ayrshire could be improved. Developed from the research in Ayrshire, they are 'Ayrshire specific' and should the lessons be taken to other localities, they would only be of value if they made sense to people in local communities and were evaluated and adapted in the light of local circumstances.

The Scottish Executive's 'Alcohol problems support and treatment services framework'¹³ recommends that those responsible for service development and delivery:

- assess local needs;
- identify service gaps and unnecessary duplication;
- take account of groups which may have difficulty accessing mainstream services;
- clarify eligibility criteria and referral processes;
- develop plans for accessible and integrated services; and

makes it clear that there will be a need to consider services at differing levels of intensity, from those of use to the community as a whole to those targeted at individuals with more

¹³ Scottish Executive (2002) *Alcohol Problems support and treatment services framework*. Edinburgh: Scottish Executive. Available from www.scotland.gov.uk/library5/health/apst.pdf Accessed 02/02/04.

complex and specialised needs. A number of core principles are outlined and it is noted that there is likely to be a link between the types and qualities of services and their take up. We believe there are significant challenges to making alcohol-related services palatable for older people and, furthermore, in making older people recognise that they may be eligible for services.

Crucially, priorities must be set. The conclusion of a study in Wandsworth¹⁴ was that there was a shortfall of services for those at the lower levels of alcohol consumption. It was argued that effective lower level services would decrease the probability of older people increasing their consumption to more hazardous levels.

One of the complexities in planning an overall strategy is that *consideration of alcohol consumption has to be seen both as an activity in its own right and as part of general service provision*. Thus proposals are outlined below for the collection of data, provision of better information and for specific services. However, it is also essential that alcohol consumption is included as part of focused service development. The report has highlighted the substantial amount of thought that has been given to campaigns to reduce falls, and noted that there is little or no mention of the potential impact of alcohol. The same is true of other work, for example on incontinence, lifting, abuse, safety and crime or discharge from hospital. Arguably, information on the impact of alcohol should permeate pre-retirement classes and healthy living approaches.

If policies are to be successful within Ayrshire, it will be imperative that there is sound collaboration between agencies and authorities. This must be much more than a paper exercise; it requires the consistent sharing of information and a willingness and capacity to work across area and agency boundaries.

Our recommendations are set out under four main headings. The four action areas are equally important and apart from the issue of staff energy and time they are not in competition with one another. The costs associated with the first three are largely those of staff time; the fourth requires money for service development. The headings are as follows:

Collection of new data on consumption of alcohol by older people in Ayrshire;
 Consideration of the effect of alcohol consumption on older people who report health or daily living problems;

¹⁴ Age Concern Wandsworth (2002) *Wandsworth Alcohol Misuse, Older People Project: final project report*. London: Age Concern.

Development of new guidance for older people on alcohol consumption; and
Development of new services.

Collection of new data

The purpose of collecting additional information on alcohol consumption and its impact on people's lives would be twofold. First, by collecting information on the drinking patterns of older people, there would be more reliable data on the extent of alcohol consumption. This would allow more detailed consideration of whether consumption poses a significant problem, thus allowing better-informed decision making about the action that should be taken. The development of services should be based upon as accurate a picture as possible of the nature of the problems for older people.

The second benefit to emerge is that the act of collecting such data will alert older people themselves and professionals to the importance of a factor in their lives that may have an impact on health or daily living. Too often, as this report has described, it is ignored.

Information could be collected from a range of sources. In some, such as primary care screening, consumption of alcohol should be a factor that is considered alongside smoking and diet. In others, information could be collected following notification of a problem, for example after a call out to someone in a sheltered housing scheme. The following should be considered as sources for collecting data: -

Primary care screening: this could be done in a number of ways. One would be to develop a pilot scheme whereby all people over 65 were screened on their next visit to a primary care location; a second way would be to add questions on alcohol consumption to any scheduled screening.

Standard single assessment for health and community care services: given that some professionals think that alcohol may be a significant factor in the need for such services, it would be appropriate, after piloting, to add questions on alcohol consumption to the forms.

Standardising, throughout Ayrshire, the reporting of problematic events: such as the needs for visits by out of hours staff to older people. Information could be collected on whether alcohol was judged to be a factor in the reason for the call out. For example, mobile attendants always do a call to sheltered units in South Ayrshire when the alarm goes and must enter a code as to the reason they have been called. The code entered could include

'problem with alcohol' - current coding includes reference to factors such as personal safety of staff at risk, which might or might not be an indication of alcohol consumption.

Standardising, throughout Ayrshire, reviews of services provided: such as those of home helps, residential homes and day centres. For example, the reasons given for admission and the numbers of residents whom staff have to monitor in relation to alcohol could be noted and used to reflect on whether alcohol contributes to the daily living problems of individuals and groups.

Standardising, throughout Ayrshire, a system for staff in any area of service provision to inform their line manager when they considered alcohol consumption to be creating a problem for the person with whom they were working. They would need to inform the individuals that they were doing this; there is a model for such a system in South Ayrshire.

Asking other services to add age to their data fields so that it is possible to interrogate all potentially relevant data sets by age, for example court records or statistics on homelessness.

Considering other data to supplement the information above, such as hospital admissions of people over 65 where reference is made to alcohol; it should be possible to ask admissions staff to monitor all admissions as to whether alcohol seemed to have any part in the problem displayed.

Recommendation 1 *Data should be collected from different sources on the extent to which alcohol consumption affects older people's daily living arrangements or their health.*

Recommendation 1a *A new question should be introduced to the standard single assessment form asking about alcohol consumption.*

Recommendation 1b *Screening of older people in primary care should include a question on alcohol consumption.*

Recommendation 1c *A system of recording should be introduced which allows a study of the occasions when alcohol is thought to be a contributory factor in the call out of out of hours staff by older people.*

Recommendation 1d A system of recording should be introduced to allow a review of the place of alcohol consumption in older people's requests for social care services.

Recommendation 1e Other sources of data should be considered for development, including the place of alcohol consumption in older people's visits to hospitals and asking other agencies such as courts and services for homeless people to record as a matter of routine the age of people that come to their attention.

Considering the effect of alcohol consumption

It is a disservice to older people to ignore the potential impact of alcohol on the problems that they report. First, being unwilling to ask people about their alcohol consumption may be part of an ageist assumption that older people have little to look forward to and so they should not be concerned about their lives. To fail to alert older people to the potential influence of alcohol on their lives, whether because of embarrassment or thinking they have not long left to live, denies the older person the responsibility for her or his own decision as to how they want to live.

It is imperative that the taking of alcohol histories becomes standard practice in primary and secondary care, and that people in social care consider the potential effect of alcohol on the lives of people with whom they are working. It is, of course, easy to write such statements and much harder to find ways of changing both the climate in which services are provided and the practices of individual staff. However, Ayrshire social care and health services should not shy away from tackling the problem. There is a danger of outsiders making recommendations that do not match the ways in which people work so, although this study makes clear the importance of recommendation 2 below, we have some hesitation in stipulating how this should be achieved.

In the literature review there are three key suggestions for policies. The first is the notion of targeting, a focus on specific groups. The second is that policies will only be successful if people want to adopt them, therefore they need to be encouraged to make responsible choices. Another approach is to see better management of alcohol consumption as part of healthy living approaches.

Recommendation 2 Older people who come to the attention of health and social care services should be asked about their alcohol consumption and should be encouraged to consider the possible impact of alcohol on their lives.

Recommendation 2a Health and social care services should consider how to ensure that older people are treated as responsible citizens who should be informed of factors that may create problems in their lives.

Recommendation 2b New training guidance should be produced, preferably as a joint document for health and social care with additional, separate sections for each service, as to how staff should approach older people's drinking habits so that they respect the rights of individuals and fulfil their obligations to understand (or diagnose) people's circumstances. Such guidance should include specific wording on how to ask questions that are not intrusive.

Developing new guidance

In spite of the availability of some useful material on ageing and alcohol consumption there is widespread public and professional ignorance, compounded by the transmission of mixed messages about the impact of alcohol on older people and on how to approach the topic.

There is a case for saying that the advice on limits currently set for adults should be maintained for older people, as it is too complicated to expect older people to adapt such limits to their own individual circumstances of body weight and metabolism. However, this study suggests that leaving the information as set currently is dangerous, in that it appears to give official sanction for drinking to such levels. In the USA the official advice given is that older people should limit themselves to one US unit per day, equivalent to one and a half UK units. This research concludes that alcohol consumption has a far greater negative impact on people's daily living than has been recognised and so people ought to review their normal patterns of drinking in old age. The official advice should reflect a significantly lower level.

Given the typical focus on the impact of alcohol consumption on health, particular account should be taken of the effect on people's daily living.

Older people do not seem sufficiently well informed to make educated choices. As one interviewee pointed out, 'We must not treat older people as if their lives are over and it does not matter what choices they make'.

Recommendation 3 A new lower advisory level for drinking in later life should be set.

Recommendation 3a *There should be a review by an interdisciplinary group of the material currently available for older people and their relatives with a view to issuing new guidance.*

Developing new services

This is the area of greatest difficulty in determining priorities. As a general test, the quality of services for older adults with alcohol problems should be compared to what is available for younger adults, recognising, of course, that the numbers in the younger group are greater. We set out some key points and highlight areas for service development but recognise that in this area we are producing a long list from which there needs to be local consideration of priorities.

There are a small number of older people in Ayrshire who are heavily dependent on alcohol. There is evidence that services for this group of people are currently limited. A number of professionals described how until recently the focus of the hospital based Addictions practice has been on people under 65; some felt that after-care for those over 65 is weak. Furthermore, there are boundary and liaison problems between elderly psychiatric services and addiction services; for example, staff in psychiatric services think that they are sometimes expected to manage in-patient detoxification without the resources or skills. In Ayrshire, an elderly mental health strategy was set up and as part of this there was scope to develop services for older people with alcohol problems; this was to happen in years 4 or 5 of the strategy but the developments were frozen in year 1.

The recommendations below set out a number of possibilities, at individual or group and community level, and for light, moderate and heavy drinkers. Overall, the greatest gap in knowledge and provision is for people who have problems consequent on light or moderate levels of alcohol consumption. Given that there is clear evidence that intervention with light and moderate drinkers is easiest and most effective, a focus on intervention strategies for these groups should be the priority. However, there is not necessarily conflict between providing better services for heavy drinkers and moderate drinkers as there are different providers involved.

The specific recommendations for the development of new services should be received within the context of more general considerations surrounding service development in Ayrshire. These might include:

working to remove catalysts or triggers for drinking in old age and helping people to prepare for imminent life changes, for example by improving social support and providing

pre-retirement health checks, counselling and advice , recognising the importance of effective interagency work involving mental health services, addiction services and generic services for older people;

attempting to keep alcohol consumption in old age within healthy parameters through educational work, development of enhanced screening processes and fostering a more consistent focus by carers, primary care staff, housing support workers and voluntary sector representatives, ensuring that these individuals know where to turn for more specialist advice and help, improving recording and reporting procedures and taking opportunities for brief interventions;

providing help for individuals to discontinue or moderate drinking in old age by ensuring that there is an effective referral system and providing a service suited to the needs of older people, recognising that individuals may have multiple needs and that effective procedures for interagency communication, referral and working are important;

introducing strategies to reduce the effects of alcohol consumption in old age - effective harm reduction strategies would perhaps need to be based on a better understanding of where, when and what older people drink than we currently have, for example, drinking at home means problems are less likely to be detected and the risk of accidents from fires or of falls are greater. Attention needs to be given to patterns of drinking as well as quantities, as this too is an important indicator of risk. There should also be consideration of other aspects of older people's lifestyles, for example, the impact of alcohol will be amplified by poor diet; and

enhancing support for older people affected by another person's drinking habits e.g. their partner, carer or other family members. Appropriate support and services should be made available and accessible to this group.

Recommendation 4 The highest priority should be given to developments that target light and moderate drinkers.

Recommendation 4a in each area of Ayrshire a post should be identified with responsibility for co-ordinating service arrangements.

It has already been suggested that information should be improved, but beyond that older people need to know where to go for help and what choices are available. Currently,

arrangements are haphazard. Throughout Ayrshire there should be local strategies that ensure that there is an identifiable post with responsibility for co-ordinating service arrangements so that there is clarity as to where to go in that area to get information about alcohol related services for older people, and the details of the services that are available.

Recommendation 4b Two types of training should be developed for health and social care staff: the first to provide general information for all staff, the second to help develop skills in brief interventions for those staff thought suitably located to undertake such work.

In terms of alcohol specific services, the development of brief interventions would be valuable. This could take the form of short counselling or advice sessions, including interviewing on motivation in a style that is reflective and non judgemental, and recognises the pushes and pulls of drinking. Different respondents in Ayrshire have highlighted the fact that services are not well designed to respond to the differing needs of individuals. A training programme should be developed for staff such as home care staff or community nurses who, with additional skills, would be well placed to provide a mix of information and space for older people to reflect on their drinking patterns. This would help to create an individualised service. It also recognises the fact that many older people are more likely to respond to support from general workers whom they already know rather than go to a new agency. The worker could also be the lead or 'key' worker, known to the older person and other professionals as the person who has an overview of service arrangements for the individual.

In addition, there should be general training for all staff working in social and health care that gives them the basic information about the problems that can develop from alcohol consumption, the signs to look out for, and knowledge of the services that are available. The key to this training is that it should provide the minimum knowledge commensurate with staff being much better informed.

Recommendation 4c A person(s) should be nominated to oversee the strategy of getting information about alcohol consumption into groups of older people and those approaching retirement.

There have been frequent references in this report to the lack of understanding of the problems that can be created for older people by even low levels of alcohol consumption. Earlier recommendations have included the development of better information for older people and staff. However, there has to be a strategy for making such information available

and it would be helpful to charge individual post holders with responsibility for overseeing the implementation of the strategy on an Ayrshire-wide basis or a more local level.

Different approaches could be taken to make the information as accessible as possible. One of the first options to consider is to influence the programmes of existing groups of older people and those approaching retirement. A list of speakers could be produced who could talk about the impact of alcohol, and alcohol consumption could become part of other healthy living programmes.

Recommendation 4d *Consideration should be given to working with older people to provide information and advice to other older people*

Recommendation 4e *Information on alcohol consumption should be brought into other programmes on services for older people; the person(s) nominated to oversee the information strategy could, in addition, be given the responsibility for overseeing this strategy.*

Another aspect of focusing on general services, rather than those that are alcohol specific, is to consider alcohol consumption in relation to other strategies being developed for older people. In this report particular attention has been given to the example of falls prevention because it has been a key focus of NHS strategies in England and Scotland. However, there are other equally relevant topics: incontinence, confusion, sleeping problems and medication problems. The impact of alcohol consumption in each of these areas is far greater than is commonly recognised and should be considered as a part of education or treatment programmes.

Recommendation 4f *Local strategies should be developed to enhance accessibility both by taking services into rural communities and by ensuring that health and social care workers who meet older people can alert them to available services.*

Service planning must take account both of the obvious, but neglected, difficulties for older people in rural communities accessing services and of the factors that stop people using available services.

Staff in Ayrshire have wide experience of trying to find means of making services available to people in their communities, rather than requiring the individual to travel in to a town centre. Options for consideration are: use of mobile services, possibly attached to other services such as mobile libraries on particular occasions; development of centres or clubs which, similarly, have occasional visiting advisors who can be seen on a confidential basis.

Accessibility should also be thought of in relation to particular groups of people who are hard to reach and less likely to use services, including physically frail older people. Several respondents noted the fact that men, typically, make far less use of groups and community centres. A further 'hard to reach group' are people who are depressed and feeling lonely and isolated. Critically, this group may be more likely to drink because of their feelings and may drink at any time of the day, outside many of the self-imposed conventions of when and with whom people drink alcohol.

The general approach noted earlier of publicising information and linking advice on alcohol to other mainstream services, such as home care and nursing, seem appropriate here. In addition, occasional targeted campaigns for such hard-to-access groups would be useful.

Recommendation 4g *There should be a review of the scope of current addiction services and of the relationship between specialist addiction services, elderly mental health services and general medicine.*

In relation to older people who are recognised as heavy drinkers, there should be a review of the scope of current addiction services and of the relationship between specialist addiction services, elderly mental health services and general medicine. People's problems cross neat administrative boundaries and it is essential that there is clarity about responsibility and availability of services. Evidence from this study shows there are insufficient services to provide an adequate specialist service for older people with addiction problems, and therefore they will come at the end of the line after the service for other, younger adults.

Further, it is clear that problems, in particular of mental health and addiction, intertwine. Thus depression and alcohol consumption may each compound the other, and act to lower self-esteem, affect sleep patterns and make it likely that people have less exercise.

Recommendation 4h *A strategy for services for older people and alcohol should be agreed on an Ayrshire wide basis, with individuals appointed with local budgets to establish services appropriate for their area.*

There have been repeated demands for 'joined up' government, a phrase that recognises the difficulties of planning and developing services across organisational divides. In Ayrshire there seems to be a history of planning and co-operative work between organisations, for example between health and social care or on specific strategies and developments. The imperative is to build on examples of good practice. Attention should

be given in relation to older people and alcohol problems to two areas: the first at an Ayrshire level is to agree and implement a strategy; the second at a local level is to develop services across and between organisations.

The commissioning group for the research is well placed to develop the Ayrshire strategy, though primary care services, in particular GPs, should be brought more centrally into the process. The commissioning group should build on the pioneering work in this field and seek funding for service development as exemplars of good practice. In particular, the suggestions of using older people as advisers might attract external financial support.

In relation to the development of services at a local level, there is a potential to encourage people from different disciplines who have an interest to take a lead in establishing services. Apart from specialist alcohol services, the development of services for older people with problems from alcohol consumption is not the sole domain of any one group. In the same way as a key worker could come from one of several disciplines, so too could someone lead the inter-agency developments. The success of such schemes is significantly enhanced if money is allocated to a budget under local control.

In trying to enhance interagency work it may be helpful to reflect on activity within this project. First, in spite of a dedicated steering group for the project, there were problems in ensuring that information filtered through to people involved in alcohol services. The project team was surprised to discover during the study that key personnel had not heard about the research, this in spite of considerable effort to publicise it through the media campaign described in the methods section of the report.

Secondly in trying to involve older people in the study, there was frequently some hostility to the suggestion that alcohol consumption might cause some problems for older people in general. If 'interagency' is to include as core members older people themselves, there must be staged strategies for their involvement. First, there has to be discussion of the sort of information contained in this report about the potential impact of alcohol consumption even at low levels, on older people's daily lives. This should be followed by consideration of the part older people might play in developing services, as members of advisory groups, giving talks to groups or directly as advisors to individual older people.

APPENDIX 1

There is a contradiction in the information we have gathered about alcohol and old age. Whether it was in a group discussion, a pre-arranged and semi-structured interview or in a chance conversation, most people we encountered – and most of the older people with whom we spoke – acknowledged that alcohol could be a problem for older people. Setting aside all the uncertainties about definition, and all the explanations for why people did or did not drink, when reduced to its basic elements the subject of this enquiry was at least recognisable – our interviewees largely understood what we were talking about.

The contradiction is that for all its apparent familiarity, alcohol was something that the majority of our older interviewees associated with other people rather than themselves. Whereas a small number of consultees denied any familiarity with the subject, and of that small number a few seemed quite hostile towards us for even raising the subject, most of our interviewees could give examples of older people who drank more than was good for them. But, with a couple of exceptions, it was all about someone else, it was not about themselves.

The association of alcohol with other people and other people's problems might be an accurate reflection of our interviewees' views and life experiences. Our contacts' accessibility for interview – largely through being participants in older people's groups of one form or another – automatically put them in a category of mobile, socially-connected older people. And as some of them remarked, we probably stood to learn less about the worst consequences of alcohol in old age by speaking to them than we would have learnt from speaking to isolated older people. And they were probably right: the people whose needs are greatest are often the ones with whom we have least contact and least knowledge. But we are equally convinced that low volume, but potentially injurious, drinking among older people is more widespread than is generally acknowledged; we are equally certain that older people are largely unaware about the health consequences of even modest levels of alcohol consumption.

The examples of 'older people who drink', of which most of our respondents could provide at least one, were largely of older people who had an identifiable, confirmed and relatively serious drink problem. There were very few examples provided by older people of health, social functioning and independence being compromised by modest or occasional alcohol consumption. This was in contrast to our interviewees who were engaged in the health, social care or housing professions, who either had a more finely attuned sense of the relative effects of alcohol in old age, or who felt less inhibited in associating alcohol with the 'normal' pattern of ageing and the general needs of older people.

It seems to us that the identifiability of alcohol-related problems in old age is in proportion to their severity, as is access to services: the more serious the problem, the more obvious the problem, the greater the likelihood of a health care intervention, but the numbers affected might be quite small. At the other end of the use-harm spectrum it is very difficult to estimate how many older people drink in ways that could possibly be harmful, partly because people do not necessarily recognise the risks associated with alcohol use in old age, or because they are not prepared to acknowledge them. But the majority of our interviewees and consultees knew older people whose lives were in some way compromised by alcohol consumption, which suggests that alcohol has a widespread if varied impact.

One of the distinctions we have tried to make in this study is between the use of alcohol by older people and 'alcoholism'. For many of our respondents this appeared to be a difficult distinction, in the sense that they only thought of alcohol as being problematic where people were clearly dependent on it, or where occasional excess could lead to an accident or injury. To illustrate the progressive impact of alcohol use in old age, and the social contexts in which drinking might be encouraged, tolerated, ignored or penalised, we have constructed a series of vignettes that seem to characterise common features of alcohol use.

The examples are real and they are drawn from the research; the only changes we have made are ones necessary to protect the identity of respondents. We have also synthesised several stories or individual experiences in the vignettes, not to make the examples 'worse' or 'better' than they would otherwise have been, but to try and capture the full range, variety and significance of broadly common experiences.

The first 'type' would be characterised by older people who drank rarely and even then only lightly, but for whom an occasional drink might compromise their medication or precipitate a fall. The second type would be older people whose drinking habits were moderate, predictable and relatively unchanged from early adult life; these might be people whose drinking pattern was unaffected by age, and who would be unaware of the affect that age and changing physiology had on their bodies' ability to assimilate alcohol. The third type would be the regular and/or heavy drinker, though not one who was necessarily known to the health services or whose behaviour was acknowledged or challenged. The fourth group would be the late-onset heavy drinker, someone whose pattern of drinking had changed in old age, perhaps as a result of a life-altering experience like retirement or bereavement. Members of this group might be quite severely alcohol-impaired, though this would have been a relatively recent occurrence. The fifth and last group we would characterise as the

extreme problem drinkers, people who had moved into old age with a high level of pre-existing alcohol dependence.

Type 1 – The Christmas party

The margin between having a good time and being miserable can be very fine indeed; the margin between behaviour being amusing and being tiresome can be equally thin. Having a drink at Christmas is commonly regarded as part of the celebrations, at least among people who drink. It might also be one of those occasions when people who rarely drink do so.

In the example reported to us the ‘problem’ did not have lasting consequences but it probably soured an otherwise happy family occasion. An elderly relative was encouraged to have a drink by the younger family members. What seemed like an amusing contribution the party spirit soon seemed anything but, as the older relative – having drunk a very small amount - became angry, slightly disorientated and demanding. This was not deliberate; no one anticipated that this would happen, but it illustrated the immediate and prolonged effects of alcohol on older people who are not accustomed to it.

Type 2 – Business as usual

For some of our consultees nothing had changed since they were young and there seemed little reason why it should now. For one thing, they did not actually think of themselves as older people and, if they had to group themselves by age band or attitude, it would be as relatively well-off, independent people in late middle age. Some of them were still in work and some had retired; what they had in common was the village pub as a significant part of their social life. They drank and some of them smoked, but neither alcohol nor tobacco were a preoccupation, they were just part of their lives.

But some respondents would pause in conversation and then reflect on what ‘growing old’ was likely to involve. They understood that the population was ageing. What was also dawning on them was the way that settlement patterns rather than longevity might substantially affect the sorts of services that would be available to them in old age. This was because they lived in villages where very few young people remained, and against that background some were beginning to wonder about the sort of social care that might be available when they really or eventually needed it. Or rather about who was going to be sufficiently young and sufficiently motivated to provide it.

Type 3 – The Doctor

Breaking glass alerted the neighbour to something being wrong, through he put it down to children throwing stones. But it was just as well that he thought to investigate, because even in the space of a minute the Doctor had lost over a pint of blood. Whether he had tripped, whether he had fallen, the result was the same; he had put his hand through a cold frame and severely lacerated his hand and lower arm; without attention he would certainly have bled to death in a relatively short space of time.

The Doctor said that he had tripped on the path, which was possible. His family wondered whether he had been drinking but his wife said not – it was just an accident. And an unfortunate accident remained the explanation for friends, relatives and the people treating the injury. But within a few days an infection set in that seemed resistant to antibiotics. This, combined with ligament damage meant that the Doctor had to be admitted for surgery, to clean the wound and to repair tissue damage.

Apparently the Doctor responded badly to the medication and to the anaesthetic. He became confused on the ward, calling out to people and having imaginary conversations. Which was strange in itself, but in the recollection of his relatives not unique; something similar had happened years before when he had been admitted for a minor operation. His wife insisted that this was all attributable to the medication. The hospital staff nodded and thought that this was probably so.

But actually it was not so. Nor should it have been much of a mystery, certainly not for the family and probably not for the clinicians. After visiting and finding the Doctor in an uncharacteristically confused state, one relative left a message asking the Registrar to call him and the Registrar duly did. The relative asked whether the confusion was really attributable to the antibiotics or anaesthetic, or whether there were other possible causes. The Registrar was not really sure. How about the symptoms of alcohol withdrawal then, enquired the relative? Oh, well we did wonder replied the Registrar, but it did not seem appropriate to ask, given that the Doctor is a well-known, senior and respected colleague.

Is this an example of collusion, denial, neglect, carelessness, embarrassment? All of these or none of them? Was it the patient's responsibility to explain whether they were sober when the accident occurred? An almost predictable feature of this story was the reluctance of close family members – particularly the Doctor's wife – to admit that alcohol could have played any part in the accident or his post-operative behaviour. But more significant seems to be the reluctance of the health care professionals to question the possible role that

alcohol had played. The Registrar did not want to question the behaviour of a patient who was also a senior colleague.

Type 4 – Numbing regrets

‘Some people live a life of regret, and (drinking) is a way of numbing those regrets’ (a statement made by one of our respondents).

Though drinking is not an inevitable response to the occasional misfortunes and tragedies of life, for some people their use or dependency on drink can be traced back to one significant event. The catalytic events described to us, however painful to the individuals involved, are common rather than exceptional: redundancy, separation and bereavement affect large numbers of people of all ages, but for an indeterminate number of older people, these kinds of life event can be the trigger for harmful alcohol use.

Events that are commonplace are also widely predicable, perhaps not for individuals but certainly for populations. We were told the stories of three older people who had experienced separation, bereavement or redundancy. In terms of location, background and occupation they had little in common, but in terms of age and isolation they were very similar, all being people who had experienced life-changing events without having the benefit of strong compensatory social supports. They had each developed the drinking patterns and persistence of long-term problem drinkers, but as ‘post-traumatic’ behaviour, which begs the question whether help at times of particular crisis could make the difference between late-onset problem drinking and there being no problem drinking.

Type 5 – Katherine and Isla’s stories

After all she had been through, Katherine thought that she knew the signs and how to hide them. She was convinced that a neighbour – a woman of approximately the same age as her, with a husband of about the same age as her husband – was living in circumstances with which she was very familiar: fear, debt, recrimination, violence and unhappiness, and all originating in drink. It was partly that Katherine saw in her neighbour the same desperation under a veneer of normality that had characterised her adult and married life. But, despite all this, Katherine has never felt able to say anything to her neighbour, because she is inhibited by the likelihood of denial and the consequent embarrassment or – worse still – the possibility that the neighbour’s husband will take it out on her.

Katherine has never known an adult life detached from alcohol, though she has never drunk herself. What appeared to be 'social drinking' by her then boyfriend and later husband possibly never was. She knew that he came from an 'alcoholic home', and that his mother and grandfather had serious drink problems, but when she was young and optimistic it did not seem inevitable that he would go the same way. And in the early years of their marriage there was no sign that he would.

But progressively Katherine's husband drank more, and he drank more frequently. He drank at home, he drank with his friends and he drank after work, and eventually – before the cumulative effects of alcohol poisoning led to his final and permanent admission to hospital – he would drink all day and every day.

By the time he died Katherine's husband had barely reached old age. He was in his early sixties, an age which is increasingly considered as being a transitional one rather than being 'old'. Another significant factor might be that Katherine's husband, despite ending up as one example of alcohol use in old age – however old age is defined - had actually been a confirmed drinker throughout his adult life. In Katherine's experience he had exhausted the potential of the health services, he had rejected counselling and support, he had blamed everybody but himself; his drinking had been largely unaffected by whatever interventions had been attempted. It was only by the time that alcohol had destroyed his capacity for independent living that the health services could intervene, by which time – for Katherine and her family – it was too late.

Katherine's experiences could be regarded as very sad, very familiar and only in conclusion relevant to the subject of alcohol and old age. On the other hand, Katherine's husband represents that group of older people with a severe alcohol dependency who have survived into old age, a group of people for whom the prospects of improvement seem very limited. Our respect for choice and the exercise of free will means that people can drink themselves into a state of progressive incapacity and the health professions will not intervene. But by the time their reasoning is destroyed the health services will intervene, but by that stage it is too late for people like Katherine and others like her.

Isla's first recollection of alcohol would have been when she was about ten years old, not for what it tasted like but for what it did to people who were close to her. After her brother was born there was insufficient room for all the family in their one room Glasgow West End tenement flat, so Isla went to live with her grandparents. But her grandfather drank a lot and her grandmother too – her only childhood escape was to lock herself in her room. She

was never abused physically, but she was repeatedly verbally abused; she could never invite friends home because of the certainty of conflict and the probability of humiliation.

Remarkably, Isla's childhood experiences or other influences have somehow insulated her from repeating in her generation the behaviour of her grandparents: she does not drink, neither does her husband, neither do her two adult children. But her parents, now in advanced old age, are also in an advanced state of alcohol dependence. And Isla still supports them. She does so alone, with the consent of her husband and children but without their participation; in fact it's probably ten years since her husband saw his in-laws and the grandchildren do not want to visit either.

Isla appears to be bound to her parents by a sense of duty, obligation or perhaps love that has been barely reciprocated, but she is not going to abandon them. From her perspective it is a shame that the health and 'helping' agencies do not share her commitment, but the problem is a familiar one to any carer or family member of someone with alcohol dependency. Isla's problem – and it is her problem – is that her parents do not accept that *they* have a problem.

Isla's mother has been admitted to hospital on about thirty occasions for alcohol-related conditions or injuries. But Isla's mother denies that she is an alcoholic, she just says that she 'takes a drink'. And whereas she can be admitted as an emergency, and be treated as such, as soon as she is discharged she can choose whether to cooperate with any other form of treatment. And she will not, as a consequence of which she is not even a prospect for counselling, home detoxification, community psychiatric care or other intervention.

Isla described an incident about ten years ago, when she stood on table in a consultant's rooms, demanding that someone should do something. And it's not that anyone was indifferent. But, one of the consequences of living in a relatively free, affluent and alcohol-accessible society is that people are also free and able to drink themselves to death, despite the unhappiness it will cause to their relatives and the costs that will ultimately fall on the health service. Isla's parents are in advanced old age, they have drunk excessively throughout their adult lives, but neither of them acknowledges that they have a problem. On that basis they will be treated when they are incapacitated, but not when they are relatively sober but in denial.

APPENDIX 2

Figure 1

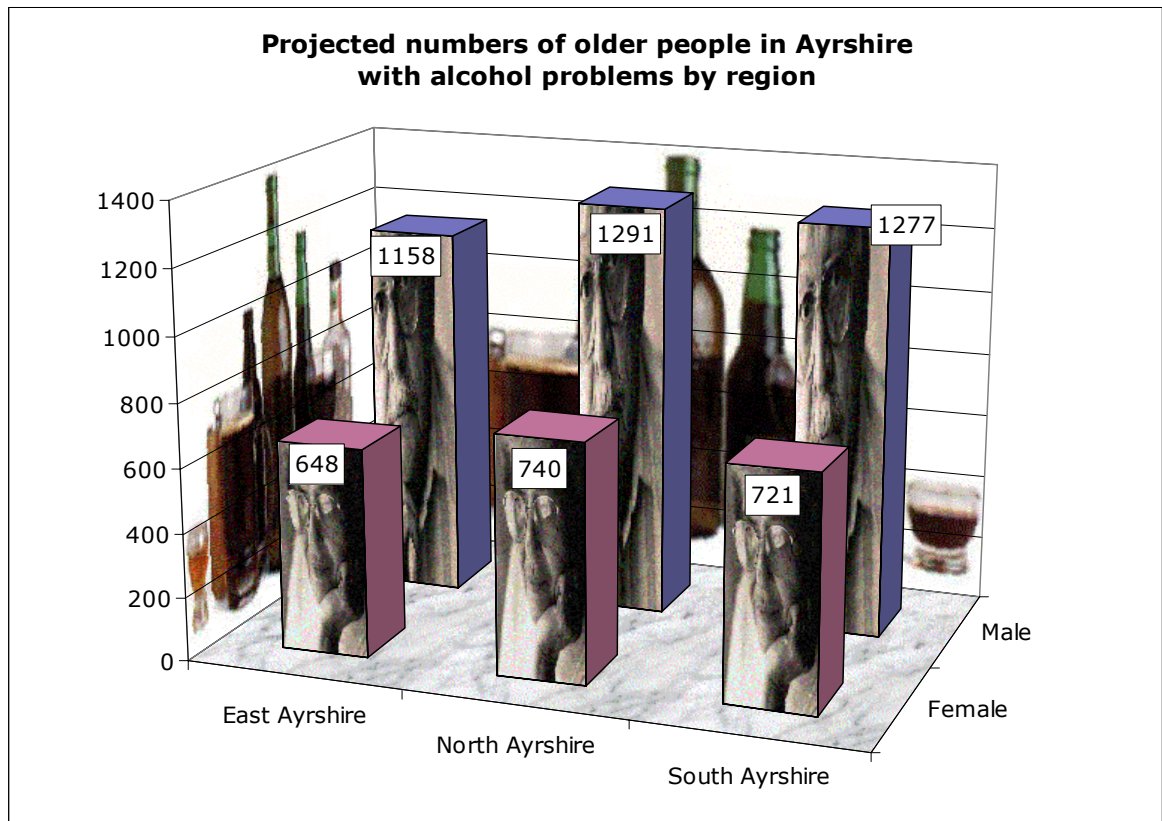


Figure 2

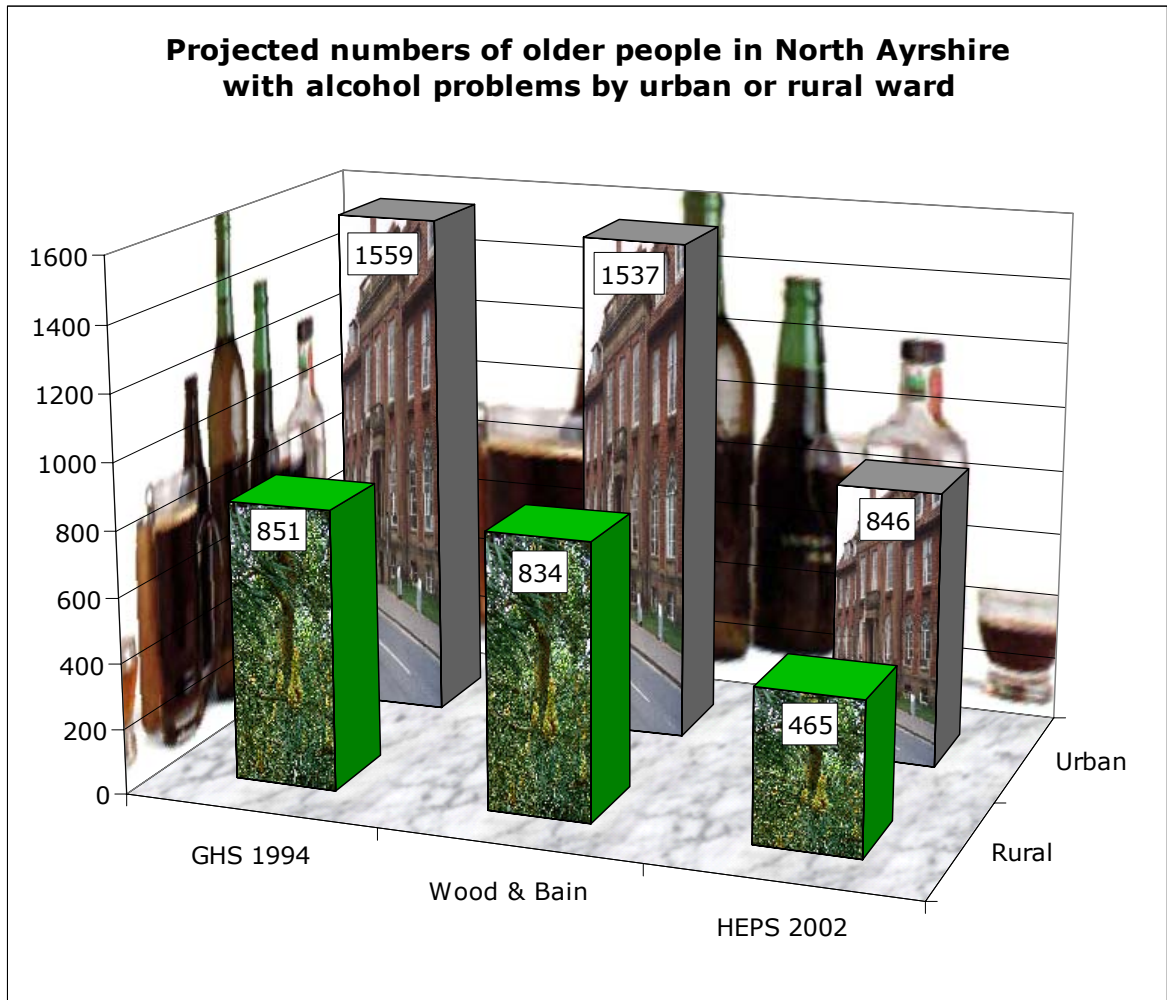


Figure 3

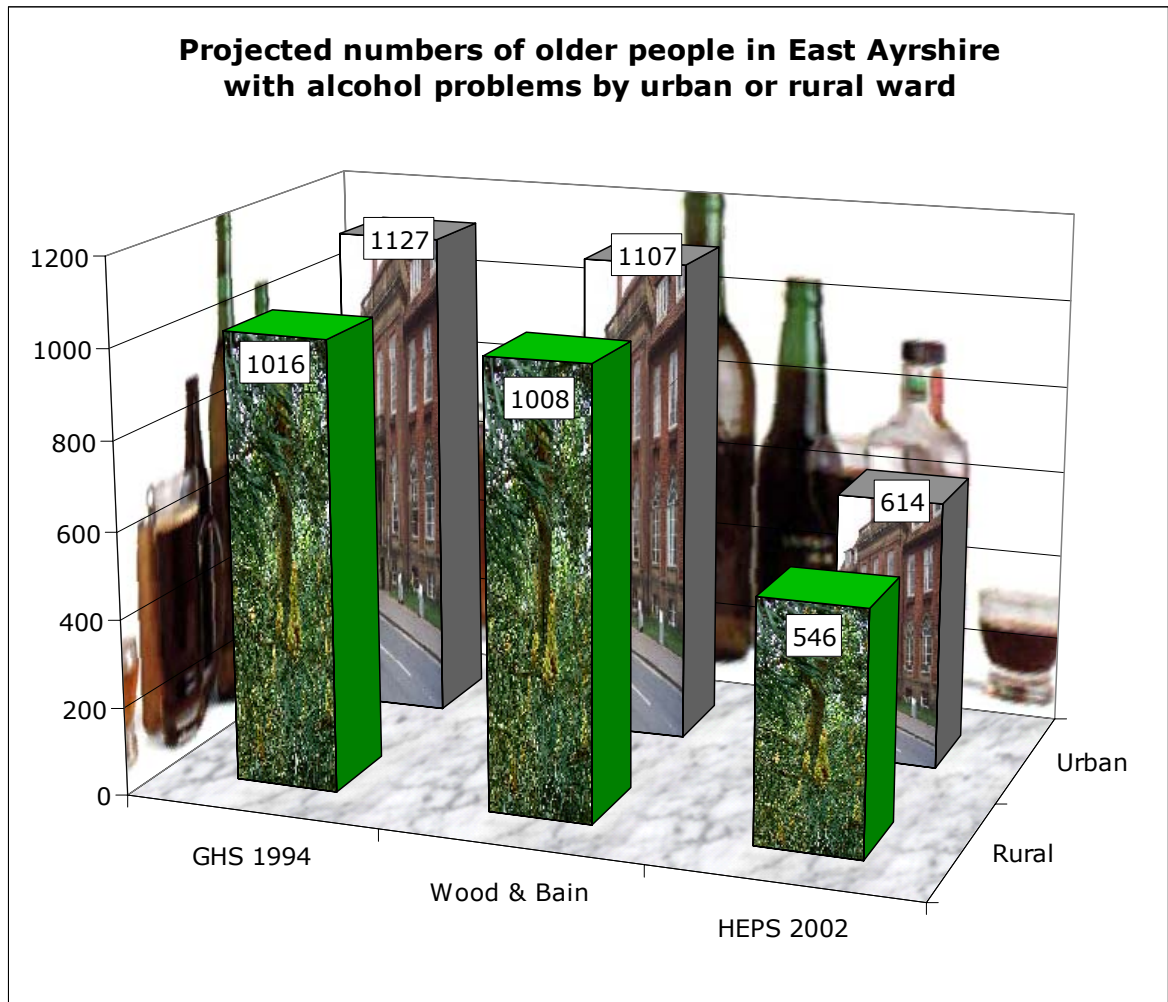


Figure 4

