Drink Wise, Age Well: Alcohol Use and the Over 50s in the UK

www.drinkwiseagewell.org.uk

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Executive Summary

This report demonstrates that there is a pressing need for action to reduce alcohol-related harm in older adults across the UK. This first State of the Nation Report from the Drink Wise, Age Well programme is a comprehensive overview of alcohol and ageing today; how much older adults drink, why they might drink and why we need to act.

Drink Wise, Age Well is a major new programme of work which will address the challenges of alcohol-related harm in older adults. Based in five demonstration areas across the UK, but with learnings shared across the nation, we will look to raise awareness of the issue of alcohol-related harm among people over 50, change attitudes, combat stigmatisation, convey harm reduction messages and influence community norms about the use of alcohol. The programme will develop a body of evidence on how to prevent and reduce alcohol-related harm in people over 50 which will inform future practice in the UK.

Informing this report is a major new survey looking at alcohol use in the over 50s population in key UK study areas. The survey, which had more than 16,700 respondents, is the first survey worldwide to specifically assess drinking behaviour in later life. The survey uses the Alcohol Use Disorders Identification Test (AUDIT) score, a method of measuring a person's risk from alcohol-related harm which goes beyond simply measuring alcohol consumption. A score of 0-7 is classified as 'lower risk', 8-15 is 'increasing risk' and 16+ is 'higher risk'. For more information on the AUDIT score, see page 11. It should be noted that the results published here are preliminary findings, and further analyses will be conducted on the survey in the coming months.

On the 8th January 2016, the four nation Chief Medical Officers proposed new recommended alcohol guidelines. Where we have been able we have taken this into account in the report, however all survey results were based on the previous alcohol guidelines set in 1995, as set by the Department of Health.

Several important findings have emerged from this research:

- The majority of survey respondents aged over 50 in the UK are 'lower risk' drinkers. However there is a significant minority who are not. 17% of the survey respondents are 'increasing risk' drinkers (those of an AUDIT score between 8 and 15), whilst 3% were found to be of 'higher risk' (AUDIT score of 16+). In terms of frequency, 17% of older respondents drink 4 or more times each week.
- The reasons given for consuming alcohol, as well as with whom they drink, varies between lower risk and higher risk drinkers. Whilst 92% of lower risk drinkers drink with someone else, only 62% of higher risk drinkers do. Whilst 1% of lower drink drinkers say they drink when down or depressed, this increases to 36% for higher risk drinkers. And 78% of higher risk drinkers say they drink to take their mind off their problems, compared to just 39% of lower risk older respondents.
- Amongst the older adults surveyed who said they were drinking more now than in the past, the five most frequently reported reasons for the increase are age-related. These were retirement (40%), bereavement (26%), loss of sense of purpose in life (20%), fewer opportunities to socialise (18%) and a change in financial circumstances (18%).
- A number of factors have been identified as being associated with an older adult being an increasing risk or a higher risk drinker. Being an increasing risk drinker is associated with being male, younger, living in Scotland, identifying as LGBT, not having a chronic illness, still being in work and not having further education after school leaving age. The factors associated with being a higher risk drinker include the first four factors listed above, along with living alone, not having a partner, being widowed and having a chronic illness or disability.
- Higher risk drinkers also are more likely to report poorer physical and mental health, whilst both 'increasing risk' and 'higher risk' drinkers are more likely to say they are unable to cope with stresses in life, unable to get emotional support from family, and not able to engage in activities they find fulfilling.
- Respondents over 50 who feel downhearted or depressed are nearly 4 times as likely to be a higher risk drinker, as are those who accomplished less than they would have liked as a result of emotional problems. We also found that the strongest predictor for being a higher risk drinker is not coping with stress. Both increasing risk and higher risk drinkers were less likely to say they were free from worries about money and less likely to say they feel part of their community.
- Around 4 in 5 of increasing risk drinkers said that on no occasion had relatives, friends, doctors or other health workers been concerned about their drinking or suggested that they cut down. 1 in 5 higher risk drinkers had never been asked. Around a quarter (23%) of respondents would not know where to go for help if they needed it, with 1 in 4 saying they would not tell anyone if they needed help.
- We have also found that 74% of respondents in the UK cannot correctly identify the recommended drink limits. When asked about attitudes towards people with alcohol problems, 20% of respondents thought that the majority of people with alcohol problems cannot recover, and 45% thought that people with alcohol problems have themselves to blame (increasing to 55% for over 65s). These attitudes held by a significant minority of older respondents in the UK indicate that there are some stigma and barriers which need to be considered when forming strategies to reduce alcohol-related harm in this age group.

One major issue identified in this report is the lack of understanding and knowledge in relation to units and recommended alcohol guidelines. The recent revision of alcohol guidelines may reduce some of this lack of clarity by reintroducing weekly guidelines rather than weekly plus daily guidelines and introducing a shared limit of 14 units per week for both women and men,

with a recommendation to spread this over three or more days, with several alcohol free days[1]. Age-related factors can lead to increased drinking; factors can include social isolation and loneliness, life transitions such as retirement and bereavement, medication use, dementia and frailty. An age-nuanced approach to strategies looking to reduce alcohol-related harm is urgently needed.

There are many stages where individuals or organisations can identify alcohol-related harm in older adults. However, we have found that these stages often lack an appreciation of the role age can have on alcohol-related harm. Government strategies and public health initiatives often focus on younger people; networks of family members, colleagues and friends who often identify problem drinking in older adults can decline in later life; both primary and acute care services often do not appreciate the relationship between alcohol-related harm and age; and treatment and service provision are often not designed with the needs of older adults in mind.

We also find that public policy is currently failing to provide a coherent strategy to combat alcohol-related harm in older adults. There is regional inconsistency; whilst Wales and Northern Ireland have alcohol strategies that particularly identify the needs of older adults, no such policies exist in England and Scotland. Given that our research shows a significant minority of respondents over 50 are at an increased risk of alcohol-related harm across the UK, this inconsistency is concerning. We have also found that government strategies and policies fail to recognise the association between alcohol-related harm and other policy areas, such as social isolation and loneliness, life transitions in older age such as retirement and age related cognitive impairment, especially dementia.

Introduction

When one is asked to think about alcohol-related harm in the UK today, the images likely to be conjured up are those of drunk young adults; the tabloid fascination in publishing pictures of chaotic drunken Saturday night scenes in provincial town centres has become almost depressingly routine. However this report, as part of the Drink Wise, Age Well Programme, aims to counter this discourse. Whilst it is important to emphasise that this issue should still be a valid concern for public health strategies, binge drinking in young adults in the UK has been steadily declining[2]. However levels of alcohol consumption and the prevalence of exceeding the recommended drink limits have remained relatively stable amongst older adults and levels of alcohol-related harm in this group are increasing[3]. The large-scale questionnaire study of over 50s which informs this report found that 20% of the respondents who drink alcohol can be classified as 'increasing risk' or 'higher risk' drinkers, a statistic with potentially significant implications if this group continues to drink in a way that places them at risk of alcohol-related harm as they continue to age.

This should be of concern to policy makers and public health professionals. This means that a significant number of our older population in the UK today are putting themselves at risk from alcohol-related harm. Older adults are also considerably more likely to drink alcohol at least five days a week than younger generations[4]. Due to age-related physiological changes, older adults can be more at risk from alcohol-related harm, even if they are drinking within current general population recommended alcohol guidelines.

It would appear the policies, strategies or cultural shifts which are having a positive impact on drinking behaviour in younger generations have not reached older adults. And as described later in this report, age is often a factor in failing to detect when a person is at risk from alcohol-related harm. A rethink from health and social care professionals, policy makers and wider society is urgently needed to address the needs of this group.

The current and future demographic profile of the UK means that this shift in attitudes and strategy is imperative. The UK's population is ageing; currently over a third of the UK population is aged 50 and over[5]. By 2032, the number of people aged 65 and over is predicted to increase by over 40%, and by 2040 almost 1 in 4 people in the country will be 65 and over[6]. Therefore if the drinking patterns of older adults in the UK do not change, the percentages of older adults at risk from alcohol-related harm will represent an increasing number of people. Especially concerning is the population bulge of people aged around 50 today. Many people in this age group are at risk from alcohol-related harm; if more of this age group are encouraged to make healthier choices about their alcohol use as they age, more people in the UK will experience a better quality of life in their later years. Drink Wise, Age Well feel that older adults in the UK have been let down by current alcohol and public health strategies so far. This first report from Drink Wise, Age Well aims to draw attention to this problem.

For this first report of the Drink Wise, Age Well research series, we will explore:

- Details of the Drink Wise, Age Well programme, including the aims and how they will be delivered.
- An overview of older adults at risk from alcohol-related harm in the UK today, including results from a significant large scale survey conducted by Drink Wise, Age Well.
- Analysis of why older adults may engage in drinking which puts them at risk from alcohol-related harm.
- Analysis of the population groups which require particular attention.
- Analysis of the difference in risk between older adults who drink and younger adults.
- A UK-wide policy overview detailing why this is relevant to policy makers today.

Methodology

This report has been informed by an evidence review using existing academic and grey literature. Existing datasets have also been reviewed and referenced in the report where appropriate. Where possible, we have referenced research and data with a UK-wide scope. However limitations and regional differences in data collecting mean that sometimes the data is country-specific. Central to the evidence base of this report is new survey data from a large scale questionnaire study of people aged 50 and over conducted by the Substance Misuse and Ageing Research Team at the University of Bedfordshire, with contributions from Glasgow Caledonian University, Glyndwr University and Queen's University Belfast, as part of the Drink Wise, Age Well programme. The postal and online survey questionnaire was distributed in five demonstration areas (programme delivery areas) and five control areas. With 16,710 respondents, it is the first survey worldwide specifically looking at drinking behaviour in later life, and provides invaluable information on the state of the nation of older adults' drinking habits and attitudes. The survey is discussed in greater depth later in this report.

Although this report presents the initial results of the survey within the 10 study areas, it should be noted that further analyses of the findings will be completed in the coming months. Also, some findings have been presented according to the different nations of the UK where the survey was collected, but it is important to point out that the demonstration and control study areas are not representative of their respective nation, nor can each nation be directly compared to the others due to differences in socioeconomic and demographic factors. The primary purpose of the survey is to measure the impact of the interventions at the end of the programme, when a follow up survey will be carried out in the demonstration and control areas.

Section 1 – About the Drink Wise, Age Well programme

Origins of the programme

Concerned that alcohol-related harm amongst older adults was not receiving sufficient attention, the Big Lottery Fund established the Rethink Good Health grant to effect change in policy and practice and reduce the harms caused by alcohol use in the over 50s population. As a result the Drink Wise, Age Well Programme was developed, with the aim of providing a comprehensive prevention-to-treatment programme which offers realistic and sustainable solutions to the growing problem of alcohol-related harm in the over 50s, as well as gaining support from policy makers at a regional, national and UK-wide level.

Drink Wise, Age Well is made up of six strategic partners. Addaction are the lead partner and, with Addiction NI and Drugs and Alcohol Charities Wales (DACW), collectively have over 300 years' experience in frontline alcohol service provision, which covers the entire UK and currently makes a positive impact on the lives of nearly 100,000 people and their families. Within the partnership, Royal Voluntary Service provide expertise on ageing issues, and are strengthened by the resource of 35,000 volunteers, some of whom will be able to act as 'peer educators'. The International Longevity Centre – UK (ILC-UK) are the leading policy experts in ageing and longevity, whilst the Substance Misuse and Ageing Research Team at the University of Bedfordshire is the UK academic lead in substance misuse and ageing. Together the partnership have worked closely to develop and implement the Drink Wise, Age Well Programme.

Aims of the programme

The overall aim of the Drink Wise, Age Well Programme is to help people make healthier choices about their alcohol use as they age and to support professionals and frontline staff to better recognise and respond to those whose drinking may be causing them harm. The programme will be delivered through a number of activities in five key UK demonstration sites and will be fully evaluated, with our learning disseminated throughout the programme life.

The core outcomes for Drink Wise, Age Well are:

- The programme will raise awareness of the issue of alcohol-related harm among people aged over 50, change attitudes, combat stigmatisation, convey harm reduction messages and influence community norms about the use of alcohol.
- The programme will both increase individual and community resilience to alcohol problems in people over 50 and also reduce increasing risk and higher risk drinking and related harm in this age group.
- The programme will increase the extent to which community service providers and employers who have regular contact with people over 50 are able to recognise and respond to alcohol-related harm.
- The programme will develop a body of evidence on how to prevent and reduce alcohol-related harm in people over 50 which will inform future practice in the UK.

How will the programme be delivered?

Drink Wise, Age Well will be implementing the programme in five demonstration areas across the UK, where the programme will provide tailored service provision and peer support to the over 50s population in each area. The main demonstration areas in the UK are Sheffield and Devon in England, Glasgow in Scotland, Cwm Taf in Wales and the Western Health and Social Care Trust Centre in Northern Ireland. These areas have been carefully selected to be representative of the diverse over 50s population in the UK, ensuring the demonstration areas include both rural and

urban areas, a range of nationalities and a range of ethnicities.

It was decided early in the planning of the programme to use an integrated approach, delivering multiple activities in each demonstration area so that the effects of the interventions would be compounded. Each demonstration area is delivered by an operational partnership team who deliver a series of activities. These include peer awareness workshops, resilience and coping skills groups, social activity programmes, workforce training and skills development, outreach and one-to-one support and family support. Central to the programme will be the recruitment of volunteers and peer educators who will provide befriending and peer support and deliver awareness workshops in any location, from work canteens to supermarkets.

Drink Wise, Age Well questionnaire study and evaluation

A key component of Drink Wise, Age Well is a large-scale survey, sent to people aged over 50 in demonstration and control areas. Control areas are being used to strengthen the case that any changes can be attributed to the programme; these areas are Dundee in Scotland, Southern Health and Social Care Trust in Northern Ireland, Betsi Cadwaladr in Wales and Lincolnshire and Derby in England. More than 16,700 over 50s completed the survey, which is, to our knowledge, the only survey worldwide which specifically assesses drinking behaviour in later life. Age-specific questions, such as life transitional reasons for increasing drinking (retirement, bereavement etc.) are included in the survey to identify the effects age can have on alcohol consumption. This report includes a number of the findings from the survey; subsequent academic papers will be published and disseminated describing the survey results in detail. A follow-up survey will be sent out in both the demonstration and control areas at the end of the Drink Wise, Age Well programme to evaluate impact, and the results widely disseminated. Throughout the programme there will be interviews, focus groups and case studies with recipients of interventions and their families to gauge impact, as well as interviews and focus groups with relevant stakeholders and Drink Wise, Age Well staff to determine elements of the programme which are successful, and those which require adjustment. Alongside this, those receiving the activities and interventions will complete a series of screening and outcome tools to measure the impact of the programme at an individual level.

Policy and public affairs

As part of the programme, each year ILC-UK will produce a ‘State of the Nation’ report. Aimed at local and national policy makers across the UK, health and social care providers and the wider public, these reports will look to raise the profile of the issue of alcohol-related harm in later life. This first report looks to provide the reader with an overview of the current situation of older adults and alcohol use in the UK today. In subsequent reports, focus will be given to a specific issue related to older adults and alcohol use. To guide and assist Drink Wise, Age Well, an advisory and impact board has been set up in each nation. The boards have representatives from charities, academia, health professionals and policy makers and will offer guidance to the Strategic Partnership Board on how best to achieve the policy objectives of Drink Wise, Age Well.

Why over 50s?

Drink Wise, Age Well acknowledges that ‘over 50’ is a wide age range, and indeed many over 50s may be surprised to find themselves described as an ‘older adult’. The age range is deliberately broad, for two main reasons. Firstly, chronological age isn’t necessarily a good indicator of the changes associated with ageing; for example a 55-year-old can experience the same age-related health changes as a 70 year old, particularly if they drink heavily. Secondly with prevention at the heart of the Drink Wise, Age Well programme, preparing people for the sometimes difficult transition into old age reduces the likelihood that they will use alcohol to cope with this transition.

Section 2 – What is the scale of the challenge?

In this section we aim to provide a current, comprehensive overview of the scale and picture of older adults at risk from alcohol-related harm in the UK today. The data presented is either from the large-scale major survey conducted as part of the Drink Wise, Age Well programme, or existing resources using the most up to date datasets available.

A definition of terms

The terminology surrounding alcohol consumption can be confusing. This report uses the terms defined below.

Lower risk drinkers

This group is defined as:

- Men who regularly drink 3-4 units of alcohol per day
- Women who regularly drink 2-3 units of alcohol per day
- An Alcohol Use Disorders Identification Test (AUDIT) score of 0-7
- This group is defined as 'lower risk' rather than 'no risk', as evidence is accumulating that no level of alcohol use is without risk entirely. This is particularly true for older adults.

Increasing risk drinkers

This group is defined as:

- Men who regularly drink more than 3 to 4 units a day, but less than the higher risk levels.
- Women who regularly drink more than 2 to 3 units a day, but less than the higher risk levels.
- An AUDIT score of 8-15.

Higher risk drinkers

This group is defined as:

- Men who regularly drink more than 8 units a day or more than 50 units of alcohol per week.
- Women who regularly drink more than 6 units a day or more than 35 units of alcohol per week.
- An AUDIT score of 16+.

At the time of completing the survey we used the current recommended guidelines, which were no more than 2-3 units of alcohol per day for women and 3-4 units per day for men, with at least 2 alcohol free days per week.

Alcohol-related harm

We have defined this as "*use of alcohol in a way that can cause psychological, physical or social harm*".

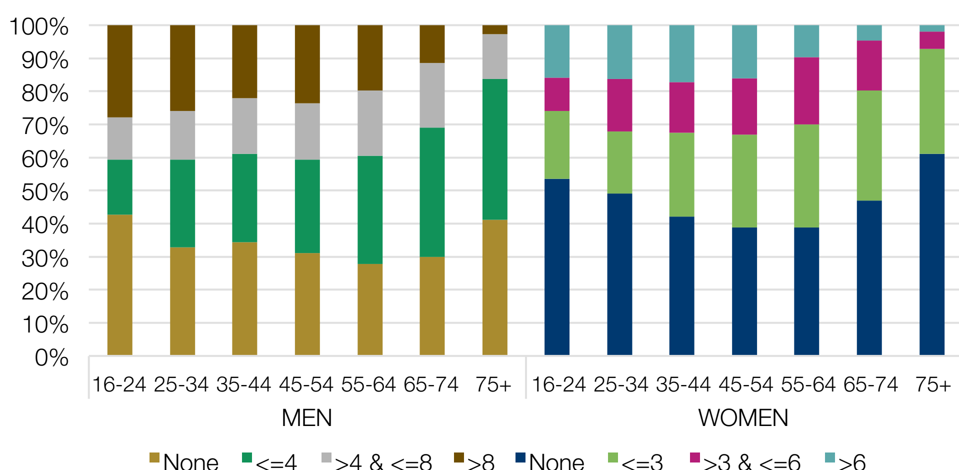
The Alcohol Use Disorder Identification Test (AUDIT) is an alcohol screening tool developed by the World Health Organisation (WHO) which uses a scoring system to measure the level of risk in relation to alcohol consumption, frequency and effects of alcohol use.

Whilst these are useful definitions, it is important to note that they do not take into consideration age, medication use, existing illness or frailty which can all influence risk of alcohol-related harm.

Alcohol consumption amongst older adults

The graphs below show data about alcohol use amongst older adults in England, Wales, Scotland and Northern Ireland. As each country collects data in different ways, there are slight differences in how we have presented the data for each country. Figure 1 shows the number of units of alcohol consumed in a given day by people in England, separated by age group and gender. We see that for both men and women, the age group with the highest proportion drinking at all is those aged 55-64. In addition, nearly of third of men aged 65-74 consume more than the daily recommended limit, whilst around 20% of women aged 65-74 do so.

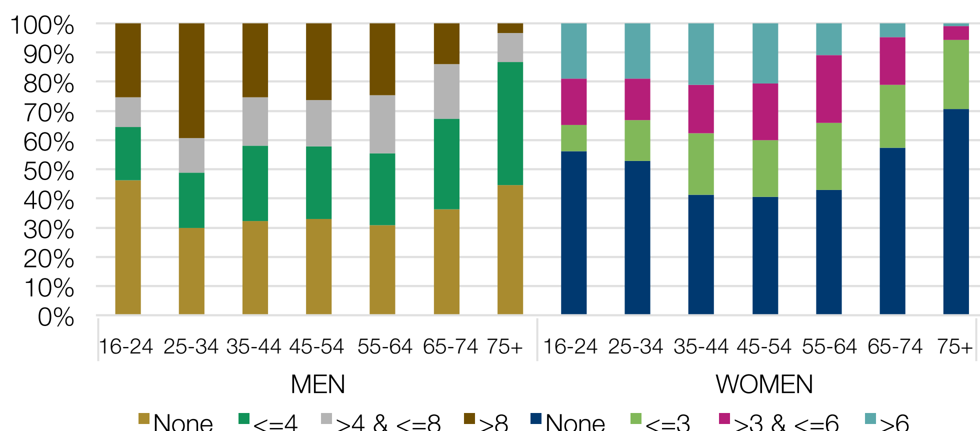
Figure 1: Daily alcohol consumption, England (number of units)



Source: Health Survey for England 2013

The picture for Scotland is not very different from that in England (see Figure 2). Amongst the older age groups, the most noticeable difference is that slightly higher proportions of Scottish people did not report consuming any alcohol at all. However, slightly higher proportions of both men and women aged 55-64 did consume more than the daily recommended limit.

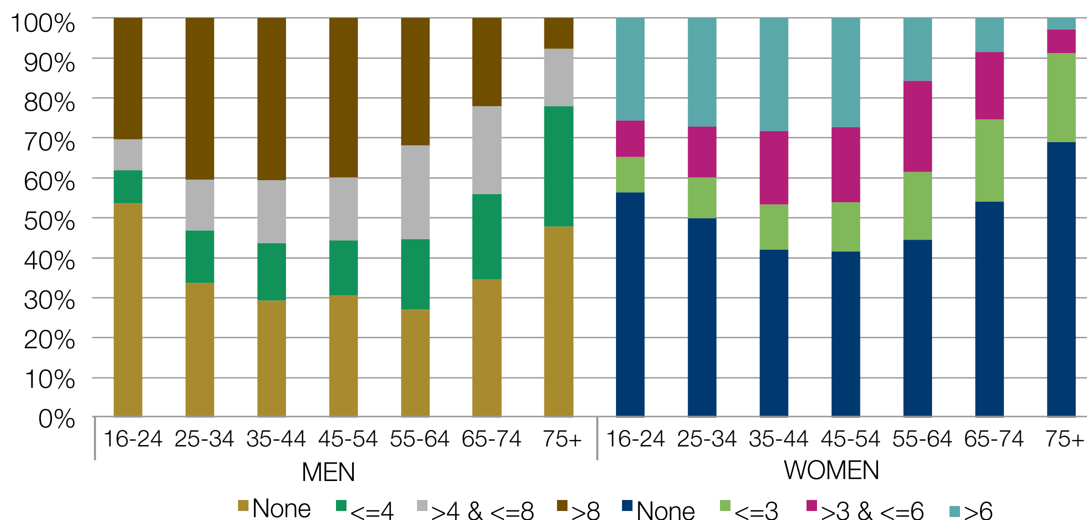
Figure 2: Daily alcohol consumption, Scotland (number of units)



Source: Scottish Health Survey 2013

Again, the pattern in Wales is not vastly different from that in either England or Scotland, with a few exceptions (see Figure 3). Welsh men aged 55-64 have the highest proportion consuming any alcohol (73%), slightly higher than in England, but higher proportions of both older men and women in Wales report consuming more than the recommended limit. Over half (55%) of men aged 55-64 consume more than 4 units, compared to 40% and 45% in England and Scotland, respectively; the proportion is 44% for Welsh men aged 65-74, with similar differences from England and Scotland (31% and 33%).

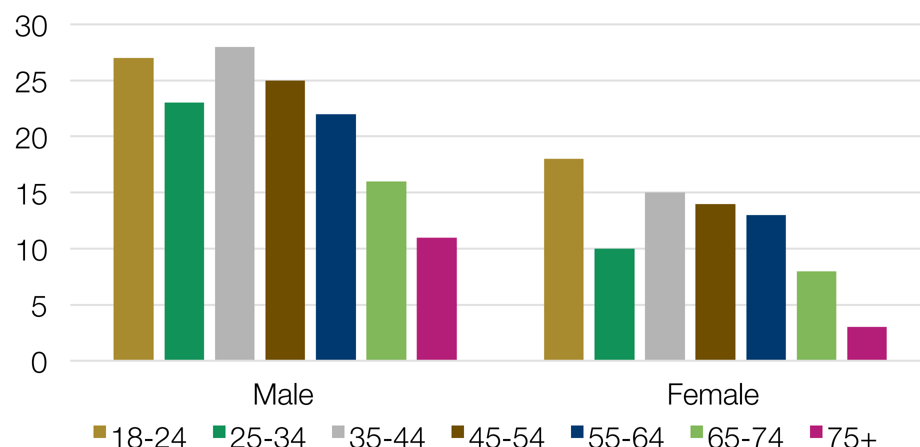
Figure 3: Daily alcohol consumption, Wales (number of units)



Source: Welsh Health Survey 2013

The data for Northern Ireland is different than that presented for the other parts of the UK, as Figure 4 shows the proportion in different age groups drinking above the recommended weekly limits. While we see a steady decline from the age group 35-44, there are still notable proportions of older people in Northern Ireland drinking above the weekly limits, with 22% of men and 13% of women aged 55-64 doing so. In addition, more than 1 in 10 men aged 75+ drink above the weekly limit.

Figure 4: Proportion of Age Group Drinking Above Weekly Limits, Northern Ireland

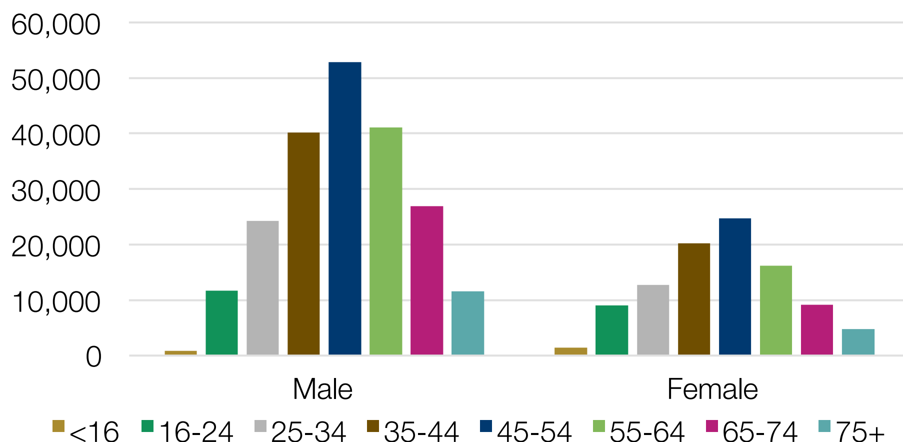


Note: Weekly limits are 21 units for men and 14 units for women.
Source: Health Survey Northern Ireland 2013/14

Alcohol-related hospital admissions

Consumption levels are only part of the picture, however, when trying to understand the health impacts of alcohol in later life. Figure 5 shows the number of alcohol-related hospital admissions in England. We see the highest number of admissions in the age group 45-54, and although consumption declines with the higher age groups, the number of admissions does not differ extremely from younger age groups, particularly for men.

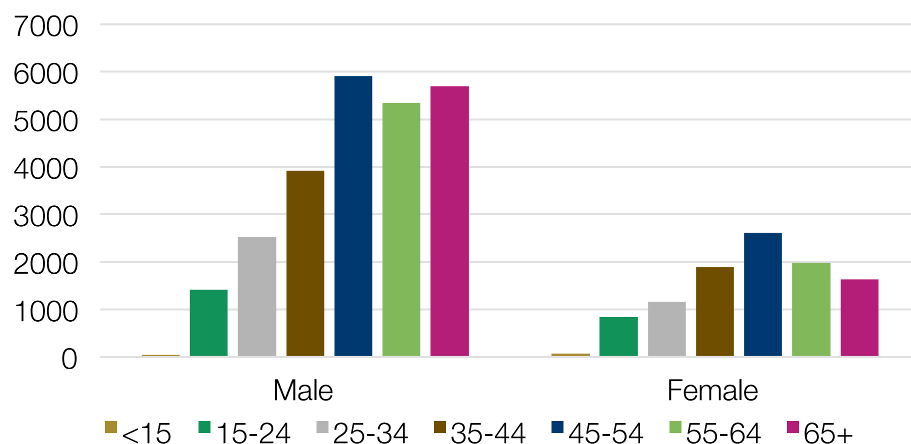
Figure 5: Number of Alcohol-related Hospital Admissions in 2013/14 - England



Note: Total alcohol-related NHS hospital admissions based on primary and secondary diagnoses (broad measure).
Source: Statistics on Alcohol, England, 2015

The same pattern is also true in Scotland, where the highest levels of alcohol-related hospital admissions appear in the 45+ age groups (see Figure 6).

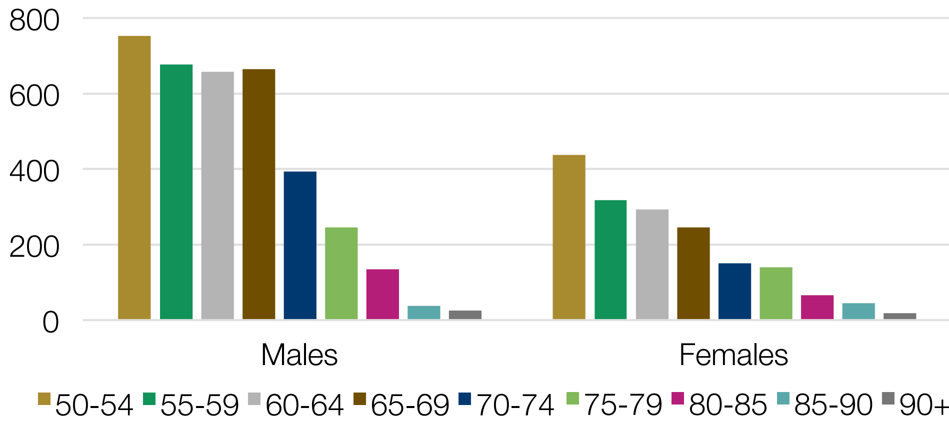
Figure 6: Alcohol-related Hospital Admissions in 2014/15 - Scotland



Note: General Acute Stays in the year 2014/15.
Source: Alcohol-related Hospital Statistics Scotland 2014/15

The figures for Wales only cover those aged 50+, and we do see a declining trend in the number of admissions with increasing age for both men and women (see Figure 7). But for men, however, the number of admissions does not begin to drop dramatically until the age of 70.

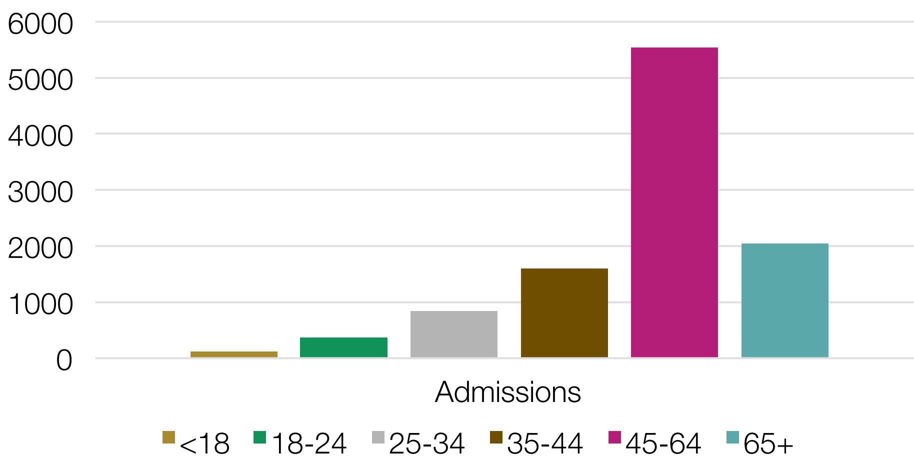
Figure 7: Alcohol-related Hospital Admissions in 2014/15 - Wales



Note: Alcohol-specific admissions, any diagnostic position.
Source: Public Health Wales

For Northern Ireland, we do not have the number of alcohol-related admissions separated by gender, but we nonetheless see that the most admissions occur amongst people aged 45-64.

Figure 8: Alcohol-related Hospital Admissions in 2013/14 - Northern Ireland

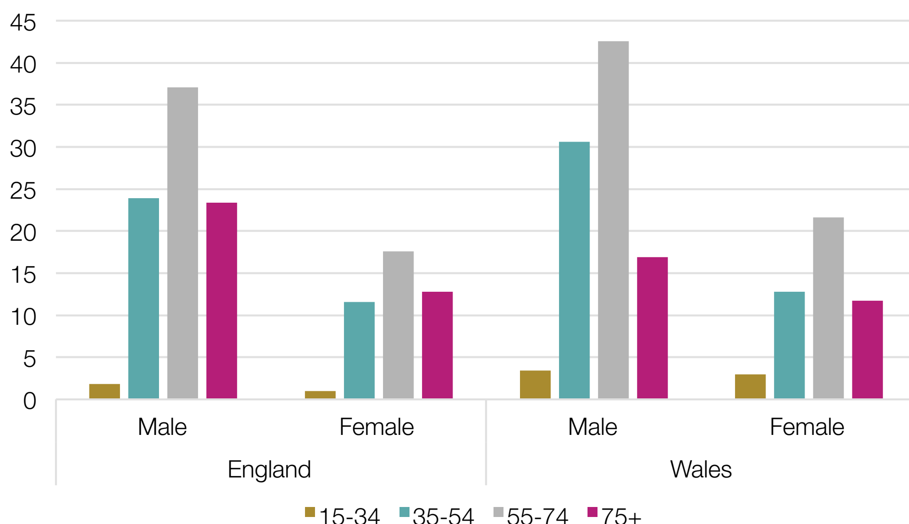


Source: DHSSPSNI New Strategic Direction for Alcohol and Drugs Phase 2 Third Update Report (July 2015)

Alcohol-related deaths

In addition to thinking about hospital admissions, we also looked at information on alcohol-related deaths. Figure 9 shows standardised rates for England and Wales, with the highest rates of alcohol-related deaths in the age group 55-74, regardless of nation or gender. Except for Welsh men, we also see similar rates for those aged 75+ and those aged 35-54.

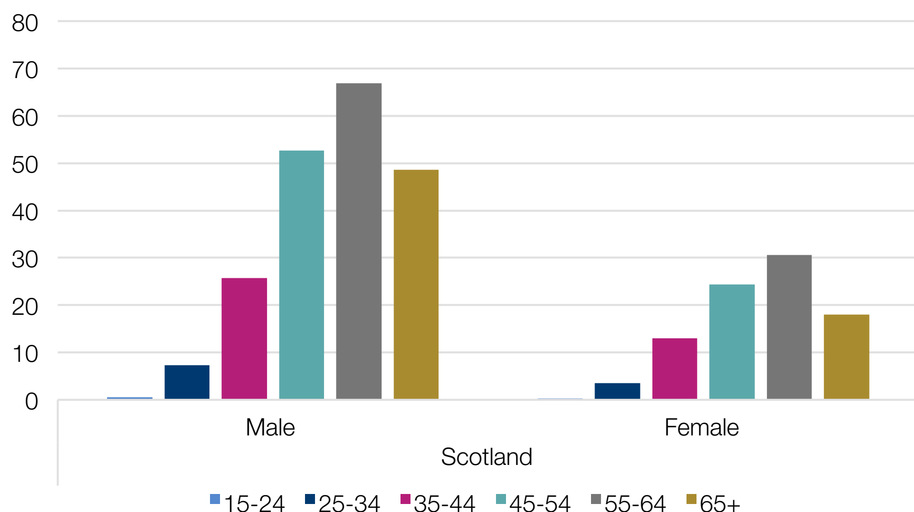
Figure 9: Age-standardised Alcohol-related Death Rates in England and Wales 2013



Note: Rates are per 100,000 population standardised to the 2013 European Standard Population.
Source: Office for National Statistics

The age breakdown is different in the Scottish data, but we again see high rates amongst the older age groups, highest for the those aged 55-64.

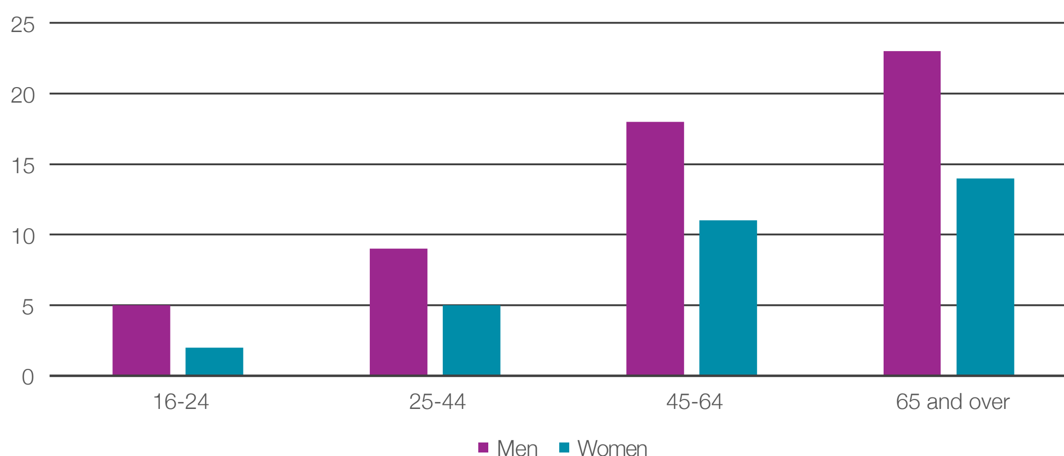
Figure 10: Age-standardised Alcohol-related Death Rates in Scotland 2013



Note: Rates are per 100,000 population standardised to the 2013 European Standard Population.
Source: ISD Scotland, SMR99 (Aug 2014)

While we could not find comparable standardised rates on alcohol-related death for Northern Ireland, the raw numbers show more deaths amongst the age group 50-64. Taken together, all this suggests that there is not a clear correlation between the effects of alcohol-related harm and levels of consumption in older adults. While consumption levels decline later in life, the impact of alcohol - at least in terms of hospital admissions and related deaths - appears most strikingly at older ages.

Figure 11: Proportion (%) who drank alcohol on at least five days in the last week, UK



Source: Opinions and Lifestyle Survey, Office for National Statistics. 2012

Statistics can only tell part of a story however, and the following information provided by two respondents of the Drink Wise, Age Well study illustrates the type of issues that Drink Wise, Age Well is trying to address.

Case Study 1

Betty, aged 72, retired, widowed, lives alone

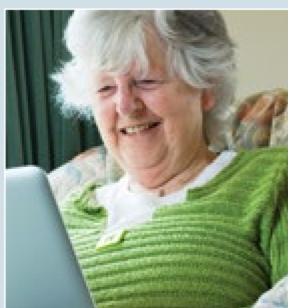


Image posed by model

- Drinks 2-3 times a week, more than 10 units on a typical day
- On weekly basis not able to stop drinking when started and had a feeling of guilt or remorse after drinking
- Drinks because she likes the way it makes her feel, to take her mind off problems, when she feels down or depressed, when she feels lonely or bored
- Alcohol impacts negatively on her energy levels and mood
- She is not coping with stresses in life, is not happy with life, doesn't get the emotional help she needs from her family, doesn't have a special person that she can share her joys and sorrows with, doesn't engage in activities that she find enjoyable and fulfilling
- Not confident in her ability to calculate or keep track of alcohol units
- Wouldn't tell someone if she had an alcohol problem
- Thinks that people with alcohol problems have themselves to blame

Case Study 2

David, aged 52, working

Image posed by model

- Drinks 4 or more times a week, 100 units in last seven days
- Drinks because likes the taste of it, likes the way it makes him feel, to be sociable and to relax
- Not worried about his drinking
- Does not know what recommended daily limits are
- Not been asked about alcohol use in last 12 months

These examples highlight the risks of assuming that the needs of all older adults at risk from alcohol-related harm is the same. Both 'David' and 'Betty' (not their real names) are clearly at risk. Both appear to lack basic alcohol awareness and knowledge of recommended guidelines. But their situations are different, and any strategies to reduce their respective alcohol-related harm needs to be nuanced to be effective.

Section 3 – What relationship do older adults have with alcohol today?

In this section, we present the preliminary findings from our survey of the 10 demonstration and control areas in the four nations of the UK. Of the 16,710 over 50s who completed the survey, 10,627 provided sufficient information on their alcohol consumption to be grouped according to the Alcohol Use Disorders Identification Test (AUDIT). AUDIT is made up of ten different items that go beyond simply asking about how much someone drinks. Those with an AUDIT score greater than or equal to 8 are considered to be at increasing risk of alcohol-related harm, while those with a score greater than or equal to 16 are considered to be at higher risk with the potential for dependence. 23% of respondents stated that they do not drink alcohol at all.

Although we wanted to explore potential variation between the different nations of the UK, it is important to note that where we present findings grouped by nation, these results correspond only to respondents in the demonstration and control areas rather than the whole national population. In Scotland, for example, this refers to Glasgow and Dundee. Further analysis is planned that will apply a weighting strategy to make the data more comparable across nations.

This section is divided into 3 parts:

- A profile of older drinkers in the UK today
- The relationship between health, quality of life and alcohol use in older adults
- Reasons for and attitudes towards drinking in later life

A profile of older drinkers in the UK today

- **The vast majority (80%) of older drinkers in the areas we surveyed are lower risk drinkers, 17% are increasing risk drinkers, and 3% are higher risk drinkers.**
- **Amongst higher risk drinkers, 72% drink four or more times per week, while 58% typically drink 10 or more units a day.**
- **People who are LGBT, are not married, partnered, or cohabiting, live alone, and who have a longstanding illness or disability are more likely to be higher risk drinkers than those who are not.**

Differences in drinking behaviour between countries

The results suggest that the majority (80%) of older drinkers in the areas we surveyed are lower risk drinkers, 17% are increasing risk drinkers, and 3% are higher risk drinkers. We see an initial degree of variation across the different countries of the UK, although the data have not been adjusted or weighted to make direct comparisons robust. Still, while the study areas in England have the highest proportion (83%) in the lower risk group, just under three-fourths of respondents in the Scottish study areas (74%) are in this group (see Table 1). In addition, **respondents in the study areas in Scotland have the highest proportion (4%) in the higher risk drinking group (compared to 2% in England or Wales) as well as in the increasing risk group (22% compared to 15% in England or Northern Ireland).**

Table 1: Level of alcohol use amongst older adults in the UK

		UK	England	Scotland	Wales	Northern Ireland
AUDIT score	Lower risk (1-7)	80%	83%	74%	79%	82%
	Increasing risk (8-15)	17%	15%	22%	20%	15%
	Higher risk/possible dependence (16+)	3%	2%	4%	2%	3%
Frequency of drinking	Monthly or less	30%	30%	31%	29%	35%
	2-4 times per month	26%	25%	27%	25%	28%
	2-3 times per week	28%	27%	28%	29%	28%
	4+ times per week	17%	19%	14%	18%	10%
Alcohol consumed on a typical day when drinking	1-4 units	75%	80%	65%	72%	72%
	5-9 units	20%	16%	27%	22%	23%
	10+ units	5%	4%	8%	6%	5%

In terms of consumption patterns, we gathered information on the frequency and typical daily levels of alcohol consumption. **Respondents in Northern Ireland study areas drank the least frequently**, with the highest proportion (35%) drinking monthly or less and the lowest proportion (10%) drinking four or more times a week. Interestingly, while respondents in the study areas of Scotland had the highest proportion of higher risk drinkers, they have a relatively low proportion drinking four or more times a week; only 14% drink four or more times per week, compared to 19% of respondents in England.

However, in terms of consumption levels, **the respondents in the study areas of Scotland appear to have a higher proportion (8%) than other countries of those who typically drink 10 or more units**; the overall UK proportion is 5%. In addition, just under two-thirds (65%) of the study area respondents in Scotland typically drink 1-4 units compared to 3 out of 4 respondents across the UK and 4 out of 5 respondents in England. This may suggest that the focus in the Scottish demonstration areas should look at efforts that address binge drinking.

Differences in drinking behaviour between risk groups

Over 1 in 10 (11%) lower risk drinkers drink four or more times per week. **Amongst higher risk drinkers, 72% drink four or more times per week, while 58% typically drink 10 or more units a day.** This again highlights the important distinction between frequency of drinking and how much a person typically drinks.

Table 2: Frequency and levels of alcohol use amongst older adults by AUDIT risk category

		Lower risk (AUDIT 1-7)	Increasing risk (AUDIT 8-15)	Higher risk/possible dependence (AUDIT ≥16)
Frequency of drinking	Monthly or less	34%	2%	2%
	2-4 times per month	29%	15%	5%
	2-3 times per week	26%	45%	21%
	4+ times per week	11%	38%	72%
Alcohol consumed typical day when drinking	1-4 units	89%	20%	5%
	5-9 units	11%	59%	38%
	10+ units	1%	20%	58%

Characterising increasing risk and higher risk drinkers in later life

There are some distinct characteristics that separate people at different levels of alcohol use (see Table 3). Compared to lower risk drinkers, both the increasing risk and higher risk drinking groups are more likely to be male, younger, LGBT, and living in Scotland. Those at increasing or higher risk (AUDIT≥8) are more likely to be free from a longstanding illness, disability, or infirmity, working rather than retired or inactive, have no education beyond minimum school leaving age, and not be providing informal care to ill family, friends, or others. In contrast, if we just focus on higher risk drinkers (AUDIT≥16), they are characterised by being more likely to have a longstanding illness, disability, or infirmity, be never-married, divorced, separated, or widowed, and live alone.

Table 3: Characteristics of increasing risk and higher risk drinkers: more likely to be…

AUDIT Score	
≥8 (Increasing and Higher Risk)	**≥16 (Higher Risk)**
Male	Male
Younger	Younger
LGBT	LGBT
in Scotland	in Scotland
Free from chronic illness or disability	To have a chronic illness or disability
	Without a partner
	Living alone
Working	
With no further education after minimum school leaving age	
Not a carer	

However, if we take into account the influence of age and gender on the different characteristics, we find that many of these characteristics do not in fact differ between lower risk drinkers and those who are at increasing or higher risk. As well as being male and younger, the only variable that remains significant is that lower risk drinkers are more likely to have further education after minimum school leaving age than those at increasing or higher risk. For the higher risk drinkers, those who are LGBT, are not married, partnered, or cohabiting, live alone, and have a longstanding illness or disability are more likely to be higher risk drinkers than not. This suggests

that **a variety of socio-demographic characteristics identify higher risk drinkers from other drinkers**, once you consider their gender and how old they are.

The relationship between health and quality of life and alcohol use in older adults

- **Larger proportions of higher risk drinkers report problems or issues on all five measures around physical and mental health.**
- **The largest differences relate to emotional problems and depression.**
- **People who say they have accomplished less than they would have liked as a result of emotional problems are over 4 times as likely to be in the higher risk drinking category as those who do not say this.**
- **People who report being limited in daily activities due to physical health as well as those saying that pain interfered with work were over twice as likely to be higher risk drinkers as those who did not report limitations or problems with pain.**
- **Those in riskier drinking groups are more likely to experience lower quality of life compared to those in the lower risk group.**
- **People who say they are not coping with stresses in their life are more than 5 times as likely to be higher risk drinkers as those who say they do cope.**

In addition to the socio-demographic characteristics discussed above, the survey also asked people about their physical and mental health. Table 4 illustrates the proportions of respondents who fall into different risk categories (i.e. AUDIT ≥8 and AUDIT ≥16) with respect to particular answers to five health-related questions.

For the higher risk drinking group, we see that larger proportions of them report problems or issues on all five measures around physical and mental health. The largest differences in the higher risk drinking group are related to emotional problems and depression.

Table 4: Proportion of respondents on health Items in different drinking categories

	AUDIT Score ≥8	AUDIT Score ≥16
	(Increasing or Higher Risk)	(Higher Risk)
In last 4 weeks limited in performing regular daily activities as a result of physical health	41%	56%
In last 4 weeks accomplished less than would have liked as result of emotional problems	26%	58%
In last 4 weeks pain interfered with normal work (outside home and housework)	48%	61%
Felt downhearted or depressed in last month	50%	78%
In last 4 weeks physical health or emotional problems interfered with social activities*	27%	51%

We can also look at the degree to which these health-related items are related to the category of alcohol-related risk, adjusting for respondents' age and gender. Table 5 shows the likelihood of being in riskier drinking categories for respondents who agree with the different health-related statements; this likelihood is expressed as odds ratios (OR).

We find that **people who say they have accomplished less than they would have liked as a result of emotional problems are over 4 times as likely to be in the higher risk drinking category as those who do not say this** (OR=4.40). We also see that those who felt downhearted or depressed in the last month were nearly 4 times as likely to be higher risk drinkers (OR=3.62). These were the only two items to be significant for the combined increasing and higher risk group overall, which may underscore the importance of addressing mental health concerns for people who are at increasing risk from alcohol use.

At the same time, we should not dismiss the potential impact of poor physical health on riskier drinking. **People who report being limited in daily activities due to physical health as well as those saying that pain interfered with work were over twice as likely to be higher risk drinkers as those who did not report limitations or problems with pain** (OR=2.68 and OR=2.19 respectively). However, it should be noted that it is not possible to determine the direction of these associations, for example, whether people increase their drinking in response to poor physical health or pain or whether higher levels of alcohol use lead to poor physical health and/or pain.

Table 5: Impact of health-related items on the likelihood of riskier drinking

	AUDIT Score ≥8 (Increasing or Higher Risk)		AUDIT Score ≥16 (Higher Risk)	
	Odds Ratio	95% CI	Odds Ratio	95% CI
In last 4 weeks limited in performing regular daily activities as a result of physical health	*NS*	-	2.68	(2.09-3.44)
In last 4 weeks accomplished less than would have liked as result of emotional problems	1.37	(1.22-1.53)	4.40	(3.43-5.64)
In last 4 weeks pain interfered with normal work (outside home and housework)	*NS*	-	2.19	(1.71-2.81)
Felt downhearted or depressed in last month	1.35	(1.22-1.49)	3.62	(2.71-4.86)
In last 4 weeks physical health or emotional problems interfered with social activities	*NS*	-	3.22	(2.52-4.11)

Notes: NS=Not significant, otherwise figures are statistically significant at the p<0.05 level. Models are adjusted for gender and age, and odds ratios reflect the degree to which respondents answering yes are more likely to fall into the specified AUDIT category compared to respondents answering no.

Quality of life

In addition to the socio-demographic characteristics and health-related items discussed above, the survey gathered people's perspectives on a number of items that broadly reflect aspects of quality of life. All but one of these items showed that less positive perspectives are more common amongst both increasing risk and higher risk drinkers compared to respondents with lower risk. Table 6 shows the different items asked in the survey as well as the proportion of people giving each response who fall into the increasing risk and higher risk drinking categories.

Table 6: Proportion of respondents to quality of life questions in different drinking categories

	AUDIT Score ≥8	AUDIT Score ≥16
	(Increasing or Higher Risk)	(Higher Risk)
Free from worries about money	78%	56%
Engage in activities find fulfilling	91%	71%
Have special person can share joys/sorrows with	87%	70%
Get emotional help and support need from family	90%	70%
Proud of community live in and feel part of it	83%	64%
In general is happy with life	93%	75%
Coping with stresses in life	95%	75%

Here we see that those with AUDIT score of 16+ are less likely to respond positively to all of the quality of life statements than those with an AUDIT score of 8+. Again, we can only identify the associations here rather than any causality; it could be that lower perceived quality of life drives people to riskier alcohol use, or the riskier alcohol use itself could influence lower perceived quality of life in either direct or indirect ways. Nonetheless, it is clear that **those in riskier drinking groups are more likely to experience lower quality of life compared to those in the lower risk group**.

As we did with the health-related items earlier, we can look further into how strongly these items are related to drinking behaviour. Again, we take into account the impact of age and gender. Table 7 illustrates the likelihood, again in odds ratios (OR), that respondents answering negatively to each question will fall into either of the riskier drinking categories. We see that **not coping with stresses in life is the strongest predictor for higher risk use**; people saying they do not cope are more than 5 times as likely to be higher risk drinkers as those who say they do cope (OR=5.22).

The impact of these quality of life items exists for both predicting being in the increasing risk or the higher risk drinking group with one exception. Those with worries about money are over twice as likely to be higher risk drinkers as those free of worries (OR=2.10), but there is no significant difference related to being at increasing and higher risk compared to lower risk.

Table 7: Impact of poor quality of life on the likelihood of riskier drinking

	AUDIT Score ≥8 (Increasing or Higher Risk)		AUDIT Score ≥16 (Higher Risk)	
	Odds Ratio	95% CI	Odds Ratio	95% CI
Free from worries about money	*NS*	-	2.10	(1.62-2.72)
Engage in activities find fulfilling	1.52	(1.30-1.80)	4.30	(3.24-5.71)
Have special person can share joys/ sorrows with	1.39	(1.21-1.60)	2.81	(2.14-3.70)
Get emotional help and support need from family	1.52	(1.31-1.77)	3.26	(2.47-4.30)
Proud of community live in and feel part of it	1.14	(1.00-1.30)	2.42	(1.86-3.15)
In general is happy with life	1.49	(1.26-1.77)	3.77	(2.81-5.06)
Coping with stresses in life	1.72	(1.43-2.08)	5.22	(3.86-7.05)

Notes: NS=Not significant, otherwise figures are statistically significant at the $p<0.05$ level. Models are adjusted for gender and age, and odds ratios reflect the degree to which respondents answering no are more likely to fall into the specified AUDIT category compared to respondents answering yes.

Another interesting insight from Table 7 relates to whether people say they engage in activities they find fulfilling. People who say they do not are over 4 times as likely to be higher risk drinkers (OR=4.30) and 1.52 times as likely to be increasing risk drinkers as those who do engage in fulfilling activities. We also see that feeling generally happy with life and having emotional support are associated with lower risk. Respondents who say they are not happy with life in general are almost 4 times as likely to be higher risk drinkers as those who say they are (OR=3.77), while those who do not get emotional support and help from their family are over 3 times as likely to be higher risk drinkers as those that get it (OR=3.26).

These findings related to quality of life reflect the importance of remaining active, having strong social connections, and feeling a general sense of wellbeing for older adults. These aspects of later life can have important consequences for older adults' physical and mental health. These findings consequently extend the importance of such elements to addressing risk in alcohol use.

Reasons for and attitudes towards drinking in later life

- **The vast majority of respondents in the UK (91%) as well as each constituent country usually drink with someone else.**
- **However, less than two-thirds (62%) of higher risk drinkers drink with someone else; this means nearly 2 in 5 respondents who drink at higher risk levels typically do so alone.**
- **Being sociable is the most important reason people say they drink alcohol, with nearly 3 out of 4 respondents in the UK reporting this (74%).**
- **While only 1% of lower risk drinkers say they drink when down or depressed, over a third (36%) of higher risk drinkers give this reason.**
- **The vast majority of respondents do not report having experienced a variety of negative consequences of drinking (93% or more).**
- **However, higher proportions of respondents in the higher risk category report that their alcohol use has negative consequences, with nearly 9 in 10 saying so (88%).**

- **Feelings of guilt or remorse and being unable to remember the night before appear more prominently for both increasing risk drinkers and higher risk drinkers than for those at lower risk.**
- **19% of higher risk drinkers say they are not worried about their drinking, compared to almost two-thirds (64%) of those at increasing risk.**
- **Yet nearly three-fourths (74%) of respondents in the UK cannot correctly identify the recommended drink limits.**
- **Around 1 in 5 respondents think that the majority of people with alcohol problems cannot recover.**

Of course, how much people drink is only part of the picture; we also wanted to know more on how and why older adults drink alcohol. We find that **the vast majority of respondents in the UK (91%) as well as each constituent country usually drink with someone else** (see Table 8). We also find that **being sociable is the most important reason people say they drink alcohol**, with nearly 3 out of 4 respondents in the UK reporting this (74%). High proportions also mentioned they drink alcohol because they like the taste or way it makes them feel or to relax or take their mind off problems. In contrast, only 3% explicitly said they drink when they feel down or depressed.

Table 8: Reasons for drinking amongst older adults in the UK

		UK	England	Scotland	Wales	Northern Ireland
When drinking, usually on own or with someone else	On own	9%	9%	10%	9%	9%
	With someone else	91%	91%	90%	91%	91%
Reasons for drinking alcohol*	Like taste or way it makes them feel	46%	50%	46%	44%	37%
	To be sociable	74%	74%	76%	74%	71%
	To relax or take mind off problems	44%	43%	46%	44%	52%
	When down or depressed	3%	3%	3%	3%	4%
	When lonely, bored or nothing else to do	3%	3%	5%	3%	4%
	When in pain	2%	2%	2%	1%	2%
	When can't sleep	2%	2%	2%	2%	3%

Note: *Respondents were able to select more than one reason.

When we look at people in different risk categories, however, we see much more variation among them in both drinking alone and their reason for drinking, and the most striking variation from the average is the higher risk drinking group (see Table 9). **While 93% of those at lower risk drink with someone else, less than two-thirds (62%) of higher risk drinkers do; this means nearly 2 in 5 respondents who drink at higher risk levels typically do so alone.** In addition, much higher proportions of respondents who drink at higher risk levels give reasons for drinking that reflect some degree of using alcohol as a coping mechanism. **While only 1% of lower risk drinkers say they drink when down or depressed, over a third (36%) of higher risk drinkers give this reason**. In addition, the proportion of higher risk drinkers reporting they drink to relax or take their mind off problems is twice the proportion reported by those at lower risk

(78% compared to 39%). Boredom and loneliness are also reflected in the reasons for drinking given by those in the higher risk category, with 42% reporting this. Moreover, in contrast to respondents in lower risk categories, only around a half (52%) drink to be sociable.

Table 9: Reasons for drinking amongst older adults by AUDIT Risk Category

		Lower risk	Increasing risk	Higher risk/ possible depen-dence
		(AUDIT 1-7)	(AUDIT 8-15)	(AUDIT ≥16)
When drinking, usually on own or with someone else	On own	8%	12%	39%
	With someone else	93%	88%	62%
Reasons for drinking alcohol*	Like taste or way it makes them feel	43%	65%	75%
	To be sociable	75%	70%	52%
	To relax or take mind off problems	39%	67%	78%
	When down or depressed	1%	6%	36%
	When lonely, bored or nothing else to do	1%	7%	42%
	When in pain	1%	3%	16%
	When can't sleep	1%	4%	22%

Note: *Respondents were able to select more than one response.

Consequences of drinking amongst older adults

Understanding older adults' relationship with alcohol also requires knowledge related to any consequences related to drinking. In terms of the different parts of the UK, we see that **the vast majority of respondents do not report having experienced the negative consequences of drinking** listed in Table 10 in the previous year. Two findings that stand out, however, are that higher proportions of respondents in the study areas of Scotland and Northern Ireland do report experiencing feelings of guilt or remorse after drinking and not being able to remember what happened the night before (10% and 11% for Scotland and 10% and 9% for Northern Ireland).

Table 10: Feelings and consequences of drinking amongst older adults in the UK

		UK	England	Scotland	Wales	Northern Ireland
Had a binge in last 12 months*	Yes	57%	51%	67%	60%	63%
	No	43%	49%	33%	40%	37%
Not able to stop drinking once started in last 12 months	Yes	5%	5%	7%	5%	6%
	No	95%	95%	93%	95%	94%
Failed to do what was normally expected due to drinking in last 12 months	Yes	4%	3%	5%	3%	5%
	No	96%	97%	95%	97%	95%
Needed alcoholic drink in morning to get going after heavy drinking session in last 12 months	Yes	1%	1%	2%	1%	2%
	No	99%	99%	98%	99%	98%
Had feeling guilt or remorse after drinking in last 12 months	Yes	7%	6%	10%	7%	10%
	No	93%	94%	90%	93%	90%
Been unable to remember what happened night before because of drinking in last 12 months	Yes	7%	5%	11%	6%	9%
	No	93%	95%	89%	94%	91%
Been injured as a result of drinking	Yes, during last year	1%	1%	1%	1%	1%
	Yes, but not in last year	2%	2%	3%	2%	2%
	No	97%	98%	95%	97%	97%
Relative, friend, doctor or other health worker been concerned about drinking or suggested cut down	Yes, during last year	3%	3%	4%	3%	3%
	Yes, but not in last year	3%	2%	3%	3%	2%
	No	95%	95%	94%	95%	95%

Note: *A binge is defined as 6+ units for a woman or 8+ units for a man on a single occasion.

When we look more closely at the different risk categories, we see that **feelings of guilt or remorse and being unable to remember the night before appear more prominently for those in both the increasing risk and the higher risk categories than for those at lower risk**.

In addition, higher proportions of higher risk drinkers also report the other negative consequences, with around a half (49%) saying they had failed to do what was expected due to drinking. Nearly a quarter of higher risk drinkers (24%) say they needed an alcoholic drink in the morning to get going, and over a third (37%) have been injured at some point as a result of drinking.

Table 11: Feelings and consequences of drinking amongst older adults by AUDIT risk category

		Lower risk	Increasing risk	Higher risk/ possible dependence
		(AUDIT 1-7)	(AUDIT 8-15)	(AUDIT ≥16)
Had a binge in last 12 months*	Yes	49%	99%	100%
	No	51%	1%	0%
Not able to stop drinking once started last 12 months	Yes	1%	15%	75%
	No	99%	86%	25%
Failed to do what was normally expected due to drinking in last 12 months	Yes	1%	10%	49%
	No	99%	90%	51%
Needed alcoholic drink in morning to get going after heavy drinking session in last 12 months	Yes	1%	1%	24%
	No	100%	99%	76%
Had feeling guilt or remorse after drinking in last 12 months	Yes	2%	24%	71%
	No	98%	76%	29%
Been unable to remember what happened night before because of drinking in last 12 months	Yes	1%	24%	69%
	No	99%	76%	31%
Been injured as a result of drinking	Yes, during last year	0%	1%	15%
	Yes, but not in last year	1%	6%	22%
	No	99%	93%	63%
Relative, friend, doctor or other health worker been concerned about drinking or suggested cut down	Yes, during last year	1%	8%	65%
	Yes, but not in last year	1%	10%	15%
	No	99%	83%	20%

Note: *A binge is defined as 6+ units for a woman or 8+ units for a man on a single occasion.

As might be expected, **higher proportions of respondents in the higher risk category report that their alcohol use has negative consequences, with nearly 9 in 10 saying so (88%)**. At the same time, over a third of those in the increasing risk category say this (35%), while almost 1 in 10 of those at lower risk do (9%) (see Table 12).

Table 12: Perceived impact of alcohol amongst older adults by AUDIT risk category

		Lower risk	Increasing risk	Higher risk/possible dependence
		(AUDIT 1-7)	(AUDIT 8-15)	(AUDIT ≥16)
Alcohol use has negative consequences	Yes	9%	35%	88%
	No	91%	65%	12%
Alcohol use impacts negatively on health†	Yes	2%	9%	45%
	No	98%	91%	55%
Alcohol use impacts negatively on relationships†	Yes	1%	4%	30%
	No	99%	96%	70%
Alcohol use impacts negatively on finances†	Yes	1%	3%	24%
	No	99%	97%	76%
Alcohol use impacts negatively on energy levels†	Yes	2%	15%	41%
	No	98%	85%	59%
Alcohol use impacts negatively on sleep†	Yes	4%	12%	41%
	No	96%	88%	59%
Alcohol use impacts negatively on mood†	Yes	1%	8%	31%
	No	99%	93%	69%
Alcohol use impacts negatively on memory†	Yes	1%	8%	44%
	No	99%	92%	56%
Alcohol use impacts negatively on ability to get out and socialise†	Yes	1%	2%	13%
	No	99%	98%	87%

Note: † These items represent different categories to a single question in the survey on the negative impact of alcohol; respondents were able to select more than one category.

We also gathered information on the ways that alcohol use has a negative impact. **Health and memory were the main impacts reported by the higher risk group, with energy levels and sleep the main aspects given by the increasing risk group**.

Personal feelings and perspectives on drinking

It is important to recognise that recommended limits and even experiencing negative consequences from drinking may only be able to do so much to impact older adults' drinking behaviour. Their own personal feelings related to drinking will certainly play a crucial role. Overall in the UK, we find that nearly 9 out of 10 respondents are not worried about their drinking (89%) yet 20% of the sample were at increasing or higher risk of alcohol-related harm. Nearly all (98%) respondents say they do not need advice for drinking and have not sought it. Higher proportions of respondents in the study areas of Scotland and Northern Ireland feel their alcohol use has negative consequences compared to the UK average (19% and 20% compared to 16% overall).

Table 13: Personal feelings about drinking amongst older adults in the UK

		UK	England	Scotland	Wales	Northern Ireland
How feel about drinking*	Not worried	89%	90%	88%	88%	86%
	Probably need to drink less or less often	13%	11%	14%	14%	15%
	Think need help with drinking	1%	1%	1%	1%	1%
Drink more now than in the past	Yes	8%	7%	9%	9%	10%
	No	92%	93%	92%	91%	90%
Alcohol use has negative consequences	Yes	16%	14%	19%	16%	20%
	No	84%	86%	81%	84%	80%
Driven with an hour of drinking alcohol in last 12 months†	Yes	18%	21%	6%	19%	14%
	No	83%	79%	94%	81%	86%
Driven when think might have been over legal alcohol limit in last 12 months†	Yes	4%	4%	5%	4%	6%
	No	96%	96%	95%	96%	94%
Sought help or advice for drinking since 50th birthday	No, don't need help or advice	98%	98%	97%	98%	97%
	No, but would have liked help or advice	1%	1%	2%	1%	2%
	Yes	1%	1%	2%	1%	1%

Note: *Respondents were able to select more than one response. †781 (around 6% of the sample) do not drive.

One area of potential concern illustrated in Table 13 is the proportion of respondents who have driven within an hour of drinking alcohol and who have driven when they think they might have been over the legal limit. **Almost 1 in 5 respondents in the UK (18%) drove within an hour of alcohol consumption in the previous year, whilst 4% of respondents report thinking they might have been over the limit**. A striking national difference is that a much lower proportion of respondents in the study areas of Scotland (6%) say they drove within an hour of alcohol consumption.

With respect to older adults' personal feelings about drinking amongst the different risk categories, we see that **19% of higher risk drinkers say they are not worried about their drinking**, compared to almost two-thirds (64%) of those at increasing risk (see Table 14). Nearly half of higher risk drinkers (49%) drink more than they did in the past. Higher proportions of higher risk drinkers have sought help or advice or say they would have liked help since their 50th birthday (19% and 20% respectively).

Table 14: Personal feelings about drinking amongst older adults by AUDIT risk category

		Lower risk (AUDIT 1-7)	Increasing risk (AUDIT 8-15)	Higher risk/ possible dependence (AUDIT ≥16)
How feel about drinking*	Not worried	96%	64%	19%
	Probably need to drink less or less often	5%	42%	76%
	Think need help with drinking	0%	1%	17%
Drink more now than in the past	Yes	5%	19%	49%
	No	95%	82%	52%
Driven with an hour of drinking in last 12 months†	Yes	16%	27%	35%
	No	84%	73%	65%
Driven when think might have been over legal alcohol limit in last 12 months†	Yes	3%	11%	30%
	No	98%	90%	70%
Sought help or advice for drinking since 50th birthday	No, don't need help or advice	99%	96%	61%
	No, but would have liked help or advice	1%	2%	20%
	Yes	1%	2%	19%

Note: *Respondents were able to select more than one response. †606 (less than 6% of this sample) do not drive.

The degree to which older adults drive after consuming alcohol shows distinct differences depending on the risk category. **Higher risk drinkers are more likely to say they have driven within an hour of drinking and when they think they might have been over the limit**, with nearly a third reporting these (35% and 30% respectively). The increasing risk group also has higher than average proportions reporting the two aspects of driving (27% and 11%).

Knowledge on alcohol units and recommended limits

We have so far discussed older adults' alcohol consumption and some of the consequences and perceptions related to it, looking also at how this information varies depending on the AUDIT risk category into which they fall. But a main driver for alcohol awareness has been the use of alcohol units and recommended limits on consumption. We wanted to know how well older adults in the UK knew about these ideas.

We found that **nearly three-fourths (74%) of respondents in the UK cannot correctly identify the recommended drink limits**, with a slightly higher proportion of respondents in Northern Ireland unable to do so (77%) (Table 15). Almost 2 in 5 respondents (18%) are not confident that they can calculate alcohol units, with nearly 3 in 5 respondents (59%) saying they are confident or very confident in their ability to keep track of alcohol units. It appears the respondents in Northern Ireland are in a worse position in these respects, with nearly a quarter (23%) not confident in their ability to calculate units and only half (50%) confident or very confident in their ability to keep track of units.

Table 15: Knowledge on alcohol amongst older adults in the UK

		UK	England	Scotland	Wales	Northern Ireland
Correctly identified recommended drink limits	Yes	26%	26%	26%	27%	23%
	No	74%	74%	74%	74%	77%
Confidence in ability to calculate alcohol units	Not confident	18%	18%	18%	18%	23%
	Somewhat confident	35%	34%	34%	36%	39%
	Confident or very confident	47%	49%	48%	46%	39%
Confidence in ability to keep track of alcohol units	Not confident	14%	13%	14%	14%	18%
	Somewhat confident	27%	26%	28%	27%	31%
	Confident or very confident	59%	62%	59%	59%	50%
Confident could reduce alcohol use if had to	Not confident	2%	1%	2%	1%	3%
	Somewhat confident	7%	6%	7%	8%	9%
	Confident or very confident	91%	92%	91%	91%	88%
Would know where to get advice/help if experiencing problems with alcohol use	Yes	77%	77%	79%	74%	81%
	No	23%	23%	21%	26%	19%

We also found that **91% of respondents in the UK are confident or very confident that they could reduce their alcohol use if they had to, with a further 7% somewhat confident**; yet we found earlier that 13% of respondents say they probably need to drink less or less often. In addition, this again appears to be more of an issue for respondents in Northern Ireland. However, respondents in Northern Ireland are much more aware of where they could get advice or help for problems with alcohol, with 81% (compared to 77% overall and 74% in Wales) saying they knew where to go.

Attitudes toward alcohol problems

We also asked respondents what they thought about different aspects of alcohol problems. **Of those respondents who gave an opinion, around 1 in 5 respondents think that the majority of people with alcohol problems cannot recover, and there is a slight difference between looking at all adults aged 50+ and just those aged 65+** (20% and 18% respectively) (see Table 16). Almost half of those respondents who gave an opinion, think people with alcohol problems have themselves to blame (45% for those 50+), with those aged 65+ thinking this more strongly (55%). Those aged 65+ who gave an answer to this question also feel more strongly that people with alcohol problems should feel ashamed (23% compared to 17% for those 50+).

Table 16: Perceptions on alcohol use amongst adults aged 50+ and 65+ in the UK

		UK		England		Scotland		Wales		Northern Ireland	
		50+	65+	50+	65+	50+	65+	50+	65+	50+	65+
Think that the majority of people with alcohol problems can recover	Yes	80%	82%	80%	81%	81%	83%	81%	83%	77%	82%
	No	20%	18%	21%	19%	20%	17%	19%	17%	23%	18%
Think that people with alcohol problems have themselves to blame	Yes	45%	55%	51%	60%	39%	47%	46%	57%	34%	44%
	No	55%	45%	49%	40%	61%	53%	54%	44%	66%	56%
Would not tell someone if they had an alcohol problem	Yes	26%	29%	24%	28%	25%	30%	27%	30%	28%	32%
	No	75%	71%	76%	73%	75%	70%	73%	70%	72%	68%
Think that society should treat people with alcohol problems with a more tolerant attitude	Yes	76%	76%	73%	72%	80%	80%	76%	77%	81%	82%
	No	24%	24%	27%	28%	20%	20%	24%	24%	19%	18%
Think that people with alcohol problems should feel ashamed	Yes	17%	23%	21%	26%	12%	15%	17%	24%	12%	18%
	No	83%	77%	80%	74%	89%	86%	83%	76%	89%	82%

However, regardless of how you group our older respondents by age, of those who gave an opinion **just over three-fourths (76%) think that society should treat people with alcohol problems with a more tolerant attitude**. In addition, a similar proportion of those aged 50+ would tell someone if they had an alcohol problem (75%). **Looking just at those aged 65+ who gave an opinion, it appears that they would be more reserved in telling someone, as nearly one in three (29%) say they would not tell someone**.

Section 4 – Groups which could be at greater risk from alcohol-related harm

The previous sections describe the current situation of older adults who are at risk of alcohol-related harm in the UK today. As well as framing the discussion in terms of the wider over 50s population in general, it is beneficial to highlight some sub-sections of the population who may be at greater risk from alcohol-related harm as they age; these groups need particular attention from policy makers, prevention programmes and service provision. It is important to note that the groups highlighted may not drink alcohol in higher quantities than the wider over 50s population (although some do, which we refer to below). However throughout this report it is stressed that the risk of alcohol-related harm does not necessarily correlate with how much a person drinks, particularly when looking at alcohol use in older adults. Life transitions, health conditions, social isolation and many other factors all impact on a person's risk of alcohol-related harm. Below we highlight these groups, using existing evidence as well as the Drink Wise, Age Well survey data where appropriate.

The 'oldest old'

Individuals at the upper age range of the Drink Wise, Age Well target audience will have specific needs and requirements. Whilst health professionals, service providers and policy makers arguably do not give sufficient attention to older adults of any age, there is particular danger of this happening with the 'oldest old'. Although definitions vary, the ONS and most other organisations define this population group as being aged 85 and older[7]. Traditionally this age group has been small in number; however their numbers have been increasing rapidly as longevity in older age has increased[8]. This age group has specific characteristics which can affect drinking behaviours. They are more likely to be frail or disabled, meaning they would have difficulty attending health appointments or service provision, as well as having an increased risk of falls[9]. This age group is also more likely to have dementia and report being in poor health[10]. Moreover an increasing proportion of the oldest old are providing unpaid care, a high percentage of them are widowed and a high percentage are living in residential homes[11]. All of this means that in order to provide information and support to this age group there is the need for strategies which are different even to the ones tailored for older adults. If this is not done, this age group, which is continuing to rapidly grow in numbers, will not be provided for.

Lower socioeconomic status

Despite prevailing narratives from the media, a lower socioeconomic status does not necessarily increase the likelihood of a person engaging in high levels of alcohol consumption. The evidence is mixed at best, but a number of studies have indicated that people living in areas of low socioeconomic deprivation are more likely to engage in excess alcohol consumption throughout the week, whilst people living in areas with higher levels of deprivation are more likely to engage in binge drinking[12 13]. Indeed this narrative of a 'hidden problem' of professional, higher-income working age people regularly engaging in levels of alcohol consumption which puts them at risk from alcohol-related harm is beginning to appear more frequently in the media and other publications[14 15 16].

What is clear, however, is that people who consume alcohol and are of a lower socioeconomic status experience higher levels of alcohol-related harm, despite drinking similar amounts (if not less) across the week than those of a higher socioeconomic status. This has been called the 'alcohol harm paradox': a paradox which means that despite these similar alcohol consumption rates, a person of lower socioeconomic status is almost twice as likely to be hospitalised or die from alcohol-related factors[17]. Potential reasons for this paradox cited include inequality in accessing health and social care services, different drinking patterns and engaging in other

unhealthy lifestyle choices (such as smoking or poor diet)[18]. Regardless of the reasons, this means that prevention and treatment programmes, public health initiatives and alcohol policy should pay particular attention to older adults in more deprived areas of the UK.

Ethnic minorities

Although Black, Asian and Minority Ethnic (BAME) populations in the UK generally drink less, levels of alcohol dependence are similar to the White population (who on average are more likely to consume higher levels of alcohol)[19 20]. There are also indications of a different relationship between age and alcohol consumption in BAME and White populations; studies have indicated that whilst alcohol consumption declines with age for White males, this is less likely in Indian and Sikh men[21]. There are however many areas of similarity in alcohol use in White and BAME populations. For all ethnicities, alcohol-related hospital admission increase with age[22], and in qualitative studies of BAME populations and alcohol consumption, the reasons for high levels of alcohol consumption in older age are similar to wider population studies: significant life events, self-medication and as a social crutch[23].

When ensuring service provision for BAME populations, there must be an awareness that older adults at risk of alcohol-related harm in some ethnic groups, particularly if they are Muslim, may have community pressures to hide their alcohol consumption[24]. Therefore service provision may have to find ways to engage with individuals who are inclined to hide their high levels of alcohol consumption due to both their age and their religion. For example, the community engagement model of placing services and health provision within the community may be ineffective in Muslim communities, who would not want to be seen accessing these services[25]. Also to be considered when engaging older generations in BAME communities is the potential difficulty in accessing services due to language barriers. Even when drinking patterns are similar to the White British population, some BAME groups are at risk because of their cultural approach to drinking and lack of interaction with services which are often not attuned to cultural differences.

Older adults in the LGBT community

The LGBT community is another segment of the population for which the relationship with alcohol in later life can be different. Available data on older LGB people's alcohol use shows that LGB people aged 55+ (male or female) indeed consume more alcohol than their heterosexual counterparts[26]. Over a third of men (35%) drink five or more days a week compared to only a quarter of heterosexual men; for women, the figures are 19% and 15%. Moreover, higher percentages of heterosexual people abstain completely compared to LGB individuals. In addition,

Figure 12: The cost to the NHS for alcohol-related inpatient admissions in England

Source: Alcohol Concern, 2012

other research has identified that LGB people are twice as likely to engage in binge drinking at least once a week compared to the wider population[27]. This existing evidence base has been reinforced by our survey data, which showed that identifying as LGBT meant the respondent was more likely to be a higher risk drinker (AUDIT score of 16 or more). We should acknowledge that the Trans community has regrettably been ignored in much of the previous research, but available data suggests that 47% report alcohol consumption that could be considered high and potentially problematic, although this figure is not restricted to older Trans people[28].

While many of the detrimental effects of alcohol consumption will impact people regardless of sexual orientation or gender identity, there are potential concerns that may in fact affect this community differently. Alcohol misuse can impact mental health, while misuse can be associated with depression, which the LGBT community is more likely to experience[29]. A great deal of socialisation in the LGBT community centres on bars and clubs, which may encourage higher consumption levels. This may be particularly significant for older LGBT people, especially those who come out or transition later in life, as these social spaces offer the most accessible place to meet and engage with other LGBT people. In addition, issues around stigmatisation, harassment, or discrimination may lead LGBT individuals to turn to alcohol as a coping strategy. There is also a question about perceived barriers and negative attitudes in healthcare experienced by LGBT people, which may mean they are less likely to be identified as at risk from alcohol-related harm. Qualitative (non-age specific) studies have indicated that there can be barriers in accessing alcohol services, which can be 'intimidating' and 'macho'[30].

Section 5 – What is different about the risks older drinkers face than younger drinkers?

It is true that people of all ages in the UK can be at risk from alcohol-related harm, and people often drink too much across the lifecourse. However policy makers need to be aware that people at risk from alcohol-related harm in later life face particular challenges and may be more prone to the harmful effects of excessive alcohol consumption. An age-blind approach to tackling alcohol-related harm will not be sufficient to meet the challenge of creating a healthier relationship with alcohol in later life; below we explore why the risks faced by older adults who drink are different and often more significant.

Physical changes as we age

There are a number of reasons as to why age-related physical changes can increase the risks of alcohol-related harm. Alcohol use can exacerbate and accelerate age-related conditions such as falls and cognitive impairment[31]. Older adults are also more likely to be regularly taking medication, with some on particularly complicated medication regimens; the combination of alcohol consumption and over the counter or prescription medication can have serious consequences in terms of treatment of pre-existing conditions[33 33]. More generally, due to physiological changes associated with ageing, it takes more time to metabolise alcohol, meaning older adults can be more sensitive to the effects[34].

Changing life circumstances

Age-related life changes or transitions may lead to an increase in drinking in later life. Of course transitions occur across the lifecourse, but many significant ones occur in later life, such as bereavement and retirement. These events could lead to an increase in alcohol consumption. Significant life events can work both ways in affecting alcohol consumption; studies have shown that for men, getting married in later life (and, significantly, remaining married) results in lower alcohol consumption, whilst not being in a relationship in later life results in, on average, higher alcohol consumption[35]. Indeed this was supported from the findings of our survey, which showed that higher risk drinkers, with an AUDIT score of 16 or more, were more likely to be divorced, separated or widowed, as well as live alone.

As we age, a person's social roles and responsibilities, such as employment and childcare, often decline. This means that alcohol-related harm could remain unnoticed, and remain under the radar of family members, health and social care professionals or service providers. Analysis of the English Longitudinal Study of Ageing (ELSA) showed that children living in the household resulted in a higher chance of an older man reducing alcohol consumption[36].

Changing life circumstances, including the impact loneliness or isolation can have on drinking habits, was addressed in the survey. The majority of respondents drank alcohol with other people, and the reason for drinking most frequently cited was 'to be sociable'. Some would argue that if the over 50s population are consuming alcohol in reasonable quantities, this could be read as 'sensible'; drinking can be a sociable activity and certainly many social gatherings for British people, regardless of age, are based around alcohol consumption. However when looking at different risk categories, the picture changes. Whilst only 8% of lower risk drinkers drink on their own, this increases to 39% amongst higher risk drinkers. And whilst only 1% of lower risk drinkers consume alcohol when 'lonely, bored, or there's nothing else to do', this increases to 36% for higher risk drinkers. This certainly shows that there is a link between loneliness, isolation and higher risk drinking which needs to be addressed.

Stigma and attitudes

Generational differences, pride or a reluctance to discuss personal problems can mean that service providers need to pay attention to the often hidden problem of older adults at risk from alcohol-related harm. Qualitative research has described how there remains a stigma of older adults and alcohol problems, which can discourage older adults to seek treatment[37]. Many feel they are “too old” for treatment programmes, feel ashamed or embarrassed, or believe they are too old to receive help[38]. In our survey, we also found that respondent’s attitudes towards alcohol use are concerning. 45% of over 50s think that people with alcohol problems have themselves to blame, whilst 26% would not tell someone if they had an alcohol problem. The differences by age seem to support the assumption that these attitudes could be generational, as these proportions increase when looking at those over 65, to 55% and 29%. However once the subject of alcohol has been initially breached, health and social care professionals often find older adults are happy to discuss any problems.

Age-specific challenges to treatment programmes

It is important again to make clear the Drink Wise, Age Well programme deliberately covers a broad age range; some of the age-related challenges discussed will be more relevant to people at the older end of the spectrum. One example of this is that older adults with mobility issues can often struggle to access treatment services[39]; it is probable this is more relevant to service provision for older adults rather than those in their 50s, although individuals of any age who have been drinking excessively for a long period of time could have neurological damage that affects their balance and ability to travel distances for appointments.

Challenges concerning medical professionals

One significant challenge is the lack of awareness amongst health and social care professionals. There is the danger that alcohol-related harm in older adults is not being detected, with symptoms being attributed to delirium, age-related cognitive impairment or side-effects from medication. Screening for alcohol-related harm and signs of high alcohol consumption also need to be nuanced by age. Screening tools which use measures based on the amounts of alcohol consumed to define hazardous drinking can be less precise, as a person becomes more sensitive to the effects of alcohol as they age[40]. There is no perfect screening mechanism, and any screening should not use alcohol consumption alone as an indicator of risk of harm in older adults. Medical and care professionals need to take into account a wide range of possible factors when looking for risks of alcohol-related harm. The Michigan Alcohol Screening Test version that is designed for older adults, MAST-G, can be useful in that it focuses on actual reasons for drinking and effects of alcohol on the individual using age-related indicators[41].

Challenges concerning awareness

There is also a generational difference regarding knowledge of alcohol units and recommended daily limits, which can make it harder to convey health messages to the over 50s population in the UK. The most recent data on this, the 2009 ONS Opinions Survey, shows that of those who have “heard of measuring alcohol consumption in units”, the lowest awareness was in the 65 and older age group. Whilst 80% of over 65s were aware of units, this was still significantly lower than all other age groups[42]. Our survey also addressed the subject of alcohol knowledge. Only 26% of the respondents across the UK were able to correctly identify the recommended drink limits, and 52% were either ‘not confident’ or ‘somewhat confident’ in their ability to correctly calculate alcohol units. Whilst we do not have an under 50s group to which to compare the survey data, the most recent ONS Opinions Survey found that 44% correctly identified recommended drink limits for men, and 52% for women[43]. This suggests there is a generational divide in knowledge of alcohol limits, although the new recommended guidelines may bridge this gap. We welcome that the revised alcohol guidelines identify older adults as a risk group under the single episodic drinking guidelines, however as older adults are more likely to drink every day we would advocate for a more nuanced approach on older adults and alcohol use throughout the guidelines.

Figure 13: Increase in alcohol-related mental health problems for the over 60s

Source: Rao, 2012

When most alcohol and public health initiatives are based around units as a measurement of alcohol consumption, this is concerning. Raising awareness and getting health messages out to older adults also means using channels and methods which public health bodies or substance misuse charities may not be used to; with messaging surrounding alcohol-related harm mostly targeting younger adults, there remains challenges to reaching non-traditional audiences.

Challenges concerning treatment programmes

Whilst evidence suggests older adults who drink often have more success in being treated successfully than younger adults, this can depend on whether their alcohol problem started in older age or earlier[44]. If an older adult receives alcohol treatment, there is the possibility, if they are an 'early onset' drinker, that they have already been through one or possibly several failed alcohol treatment programmes[45]. This could mean that a sense of failure is carried with them, with a reluctance or disbelief that any treatment programme could work. On the other hand, it is also the case that sometimes older adults who have had alcohol problems for many decades can be extremely motivated to change, due to them hitting 'rock bottom'.

These two arguments highlight the need for health and care professionals, as well as treatment programmes, to treat adults of any age as individuals each with different needs. Older adults at risk from alcohol-related harm often bring with them more complex needs than younger people at risk from alcohol-related harm; alternatively, long-term older drinkers could be more determined to reduce their alcohol consumption. Treatment, awareness and prevention programmes need to be aware of the particular age-related factors which are in play when providing these programmes. But chronological age is not the be all and end all; treatment programmes should take age into consideration, but should not let it solely define treatment strategies.

Missed opportunities – why are older adults falling through the net?

In this section we highlight some of the ways in which risks from alcohol-related harm can be detected and successfully dealt with. As shown, each potential intervention stage lacks an appreciation of the role age can have, with attitudes which sometimes can border on ageist. This demonstrates why urgent and additional attention to older adults at risk from alcohol-related harm is needed.

Government strategies and public health initiatives

Older adults are often missing from campaigns and public health initiatives aimed at reducing alcohol-related harm, such as drink driving campaigns. This is despite drink and drug driving prosecutions for older adults increasing in the UK, as well as older adults usually needing less alcohol to become intoxicated. A comprehensive knowledge of the scale of the issue is also hampered by ageist attitudes in data collection, such as statistics on alcohol treatment in England having up until now a cut off at over 75 years of age.

Family members, colleagues and friends

If an older adult's problem drinking is overlooked by health and care professionals, sometimes it can be family members, friends or colleagues who identify someone at risk from alcohol-related harm. However as we age these networks often become smaller; retirement, children moving away and, in later life, an increased chance of social isolation all are factors. This means that whereas in younger years early signs of alcohol-related harm can be detected, these opportunities can often shrink in later life.

GP and primary care

The GP is usually the first port of call for a medical complaint, and often the health professional that an older person sees most regularly. However there is sometimes a perception that at-risk drinking is an issue for younger patients; GPs also need to be aware of the potential harm from patients mixing heavy alcohol consumption and prescribed medication. There is also the danger that an older person is drinking within the recommended guidelines but, due to an underlying health condition, it is having a negative impact. And even if an alcohol problem is identified by a GP, an older person is often treated for the alcohol-related health problem, rather than for the drinking itself.

Hospitals and other acute care settings

There is the danger of alcohol-related harm being misdiagnosed as delirium, memory problems or side effects from medication. Although screening for drinking levels exists, these are often not age-specific. As a person ages it becomes more difficult for the body to break down alcohol. Therefore what could be considered low-risk drinking levels in younger patients could be having adverse effects on older adults.

Treatment and service provision

Even if an older person has been identified as being at particular risk from alcohol-related harm and directed towards treatment and service provision, ageist attitudes and simple barriers can prevent them from engaging and being successfully treated. Some alcohol services, such as rehab or detox services have an upper age cut off at 65. And even without an upper age cut off, substance misuse treatment centres are often designed around younger adults, and alcohol misuse treatment programmes are often in the same place as drug treatment programmes. This can be an intimidating or inaccessible place for older adults. Amongst referrers of older adults to treatment services, such as GPs and social workers, there is the danger of a prevailing attitude that they are 'too old to treat'.

Figure 14: Increase in alcohol-related deaths amongst the 55-74 age group in England

Between 1991 and 2010, alcohol-related deaths amongst the 55-74 age group in England have increased by:

Source: NHS Information Centre, 2012, and ONS, 2012.

Difference between late onset and early onset drinking in the over 50s

It is important to emphasise that the over 50s are not a uniform group. Each older adult at risk from alcohol-related harm will have different needs. This table demonstrates the differences between 'early onset', those who have reached older age already at risk from alcohol-related harm and 'late onset' drinkers, those who first developed an alcohol problem in later life.

Characteristic	Early Onset	Late Onset
Alcohol consumption	Higher	Lower
Alcohol-related problems	More	Fewer and less severe
Alcohol dependence	More likely	Less likely
Binge drinking	More likely	Less likely
Social resources	Fewer	More
Psychiatric comorbidity	More likely	Less likely
Family history of alcohol problems	More likely	Less likely
Life satisfaction	Poorer	Greater
Treatment prognosis	Poorer	Better

Source: Dr Sarah Wadd

Section 6 – Why is the issue of alcohol and ageing relevant to policy makers today? A UK-wide policy overview

Policy concerning older adults and alcohol-related harm is inconsistent at best, and non-existent at worst. It is problematic that whilst there are policies and strategies regarding alcohol and ageing in some of the UK's nations, in others there are not. Wales and Northern Ireland have more developed strategies on older adults and alcohol harm; in Wales there is the Welsh Strategy for Older People 2013-23, which includes a commitment to provide information and advice to older adults about alcohol misuse. There is a commitment "to raise awareness and understanding of issues associated with substance misuse in older age", and they will monitor the number of referrals of people aged 50+ to substance misuse services[46]. Similarly in Northern Ireland the New Strategic Direction for Alcohol and Drugs 2011-2016 includes as a key priority "older people drinking hazardously, dangerously, or dependant on alcohol"[47].

In England and Scotland, however, there is little to no reference to older adults at risk from alcohol-related harm in substance misuse or public health strategies. Alcohol-related harm is not included in key ageing policies or best practice guidelines and, similarly, older adults are not included in the main alcohol and substance misuse strategies. There is also little consistency in the collection of data which can aid strategies to reduce the risks of alcohol-related harm for older adults; for example in Alcohol Statistics England there is no section on older adults, whilst in Wales this is included.

Why is this relevant to public policy today?

If there is to be a public policy response to the issue of alcohol-related harm in older adults, it is important for the response not to be siloed; there needs to be an appreciation that older adults at risk from alcohol-related harm pertains to a number of current policy issues and therefore should be included in any strategies relating to these. An obvious start is health and social care; there needs to be more awareness amongst health and care professionals about the growing issue of older adults experiencing alcohol-related harm. Moreover older adults disproportionately cost the NHS more to treat for alcohol-related harm than younger generations[48]. Another relevant policy development of recent years is the growing call for mental health to be given the same parity as physical health, with references to mental health provision in every main political party manifesto at the last election[49]. However there is a clear need for older adults at risk from alcohol-related harm to be included in any mental health strategies, considering the disproportionate increase of 150% between 2002 and 2012 in alcohol-related mental health problems in the over 60s in England[50].

Figure 15: Prosecutions for drink or drug driving for 65+ group

Prosecutions for drink or drug driving have increased by

over 40% in those aged 65+

during the period 2000-2009

Source: Wadd, 2014

Social isolation and loneliness

One of the biggest developments in policy and public discourse of recent years is the much overdue recognition of the problem of loneliness and social isolation amongst older adults in the UK. In England, 14% (1.2 million) of older men reported moderate to high levels of social isolation, as well as 11% of older women[51]. Research has shown that whilst social isolation affects both older men and older women, men are more likely to have less social contact with friends and family[52]. This is of particular concern when discussing the relationship between alcohol and loneliness, as older men are more likely to be at risk from alcohol-related harm than older women. Indeed the Drink Wise, Age Well survey found relationships between higher risk alcohol consumption and isolation; higher risk drinkers are more likely to usually drink on their own than lower risk drinkers (39% compared to 8%), more likely than lower risk drinkers to drink because they are lonely (42% compared to 1%), and more likely to drink because they are down or depressed (36% compared to 1%). There needs to therefore be a greater emphasis on the relationship between social isolation and alcohol-related harm, in order to effect change in both areas.

Life transitions

Also highlighted in this report are the implications major life transitions in later life can have on alcohol consumption and alcohol-related harm. Retirement is a major life transition as people age, with people suddenly finding themselves with free time and often a loss of purpose. A number of studies have found a relationship between retirement and increased alcohol consumption, although it is often dependent on gender (men have been found to drink more) and type of retirement (involuntary or retirement due to ill health has been linked with increased drinking)[53 54].

A recent piece of research also found that, from analysis of the drinking habits of over 50s in England, risk of alcohol abuse increased in younger, better educated males with high incomes[55]. This should be on the radar of health policy makers due to the possibility of this group continuing high levels of alcohol consumption after retirement and into older age, possibly leading to further increases in alcohol-related hospital admissions and subsequent costs to health and social care systems.

However our survey analysis showed that those classed as increasing or higher risk drinkers, with an AUDIT score of 8 or above, were more likely to be still in work than those who are lower risk drinkers. What is clearly important however is how well people transition between work and retirement. Higher risk drinkers are more likely to have a chronic illness or disability; therefore if a person is forced to retire due to a chronic illness, this could increase the likelihood of higher risk drinking. Life satisfaction and fulfilment are also important when considering the impact of retirement and alcohol consumption. The survey respondents who reported not engaging in activities they find fulfilling were more than 4 times more likely to be higher risk drinkers, and 1.5 times more likely to be increasing or higher risk drinkers. There is a similar relationship between higher alcohol consumption and not feeling part of a community. Clearly then, if the transitions between work and retirement are not managed well, some older adults may be at risk of increased alcohol use and alcohol-related harm.

Dementia

The issue of older adults who are at risk from alcohol-related harm also needs to be incorporated into dementia strategies in the UK. As with social isolation, increasing prevalence of dementia and successful awareness raising has seen policy makers and the wider public in recent years become increasingly conscious of its impact on the lives of the people it affects, and the impact it has on health and social care systems in the UK. Again there is a siloed approach to combatting the two issues of alcohol-related harm and dementia, when the two are often connected. Some forms of dementia are specifically caused by long-term excessive alcohol consumption, such as Korsakoff's syndrome[56]. More generally, the evidence on whether alcohol use is a risk or protective factor for most types of dementia is mixed. Whilst some studies have indicated that

Figure 16: Alcohol-related hospital admissions amongst the group aged 65+

Source: Wadd, S. 2014. Drinking behaviour and alchohol-related harm amongst older adults: analysis of existing UK datasets.

even moderate alcohol consumption can increase the risk of developing dementia in later life, others have indicated that low levels of alcohol consumption may delay or prevent cognitive decline[57 58]. There is a need therefore for more joined-up messaging on these two issues from public health bodies; alcohol needs to be part of awareness campaigns and strategies about dementia, and dementia needs to be part of awareness and strategies about alcohol.

What works? Lessons from case studies

Drink Wise, Age Well is looking to create a 'ripple effect' to change drinking behaviours throughout the UK's over 50s population, and help people make healthier choices about their alcohol use as they age. It is important to therefore review the evidence and analyse some of the components of useful interventions.

Several caveats are important. The case studies we have selected in this section are not uniformly accepted as best practice, and are not necessarily thoroughly evaluated with demonstrable outcomes. They are instead interesting examples of programmes or initiatives of targeted health interventions in older populations. Also, as highlighted in this report, the age scope of Drink Wise, Age Well is broad. The needs and behaviours of a 50 year old can be markedly different than that of a 75 year old. Moreover over 50s in the UK differ markedly in their alcohol consumption, socioeconomic status, ethnicity and religion. When using international examples it is important to remember the differences in drinking cultures worldwide. Traditionally the distinction has been made between 'wet' cultures, with alcohol ingrained in daily meals and routines, and widely available (examples of these cultures are Southern European countries), and 'dry' cultures which have a history of restrictions on alcohol consumption, with alcohol often not consumed with everyday meals and a higher tendency to use alcohol as an intoxicant (examples often cited are the USA and Scandinavian countries, and sometimes the UK)[59].

Case study: City of Espoo Home Care Service, Finland

The Lippajavi-Jupperi home care service in Finland has been developed with several NGOs and the Finnish Nurse Association to reduce alcohol-related harm in older adults. With the aim of providing early intervention, when a care plan is formulated, substance abuse is brought up and any issues addressed carefully. If the client has a high AUDIT score, comprehensive interventions are planned for the older adult, with support from any care givers and other support services. Interventions could include drink diaries, pharmacy agreements to ensure any medication prescribed will not be affected by alcohol consumption and consultation with mental health services. It is ensured that staff are given as much information as possible about alcohol-related harm in older adults, and the risk of assumptions and ageist attitudes are discussed with all staff involved[60].

Case Study: Age-specific Strategies in Italy

In Italy, alcohol consumption guidelines exist for the entire population and for specific age groups, including older adults. In these guidelines, alcohol consumption is described in terms of "standard drinks", where, in Italy, a standard drink commonly contains 12 g of pure alcohol. The guidelines recommend that older adults do not exceed one alcoholic beverage daily. In addition to these guidelines, the National Public Health Institute has a clinical guideline for the identification of alcohol problems and brief intervention strategies for the general population. These guidelines are intended for primary health care providers (physicians and nurses), managers, educators, financers and evaluators of primary health care services. The guidelines aim to advise health care providers about the techniques for assisting people who are at risk from alcohol-related harm[61].

Case Study: Older Focus Service in Northern Ireland

Older Focus, part of Addiction NI, is the first specialist alcohol treatment service for people aged over 50 in Northern Ireland. A key focus of the service has been increasing accessibility for older people and a number of service features were incorporated to assist in this, e.g. provision of age-specific information leaflets and home base appointments. Older Focus offers counselling, group work, referrals to community support networks and family counselling. Post-treatment data highlights not only the real changes individuals make in relation to alcohol consumption but also in relation to mental health, social engagement and relationships.

Case Study: REAP, Rural New Hampshire

The REAP (Referral, Education, Assistance and Prevention) service in New Hampshire provides an early intervention community-based programme to engage and support older adults. The REAP programme is specifically tailored to address the needs of older adults at risk for mental health and alcohol use disorders in a rural community. Referrals primarily come from housing agencies, mental health services and social work. REAP offers age-sensitive screening and assessment for older people using an outreach model.

A full analysis of what makes a successful alcohol intervention strategy is beyond the scope of this first State of the Nation report. As the programme progresses we will learn what can work, and what cannot, with findings disseminated. It is worth stating however that policy developments rarely affect behavioural change autonomously. Economic, cultural and societal factors usually all have a significant impact. Moreover there is scope for both population-level strategies (such as minimum unit pricing and restrictions on availability) and targeted interventions, which look to change particular behaviours related to alcohol consumption and specific population groups[62]. Priority needs to be given to implementing successful partnerships with a range of actors including national and local government, health and social care systems and charities.

Policy challenges

Any behavioural change often requires a mixture of new legislation or new policy direction, financial advantages (or disadvantages) and social influences working together. Regarding policy, strategies on reducing alcohol-related in harm in older adults is hindered by the lack of consistent UK-wide data on the subject. This makes it harder to construct a policy strategy to tackle the problem and deliver service provision to those who will most need it.

For any government strategy to respond to the problem of older adults at risk from alcohol-related harm, there needs to be a realisation, both from policy makers and health professionals, of the societal context of alcohol in the UK. Alcohol often plays a significant role in how many people in the UK socialise, relax, celebrate and even commiserate. Behavioural change concerning something as ingrained as alcohol consumption in the UK is difficult, and a policy approach which is nuanced and realistic is advised. There is still the perception amongst the UK population that alcohol is somehow not a drug, and there is (although recent trends show alcohol consumption is beginning to decline) an ingrained drinking culture in the UK[63].

There is also often an aversion from the British public towards a 'nanny state' when it comes to alcohol legislation (or indeed other legislation). There is the potential for a double jeopardy in any messaging concerning older adults and alcohol; an aversion to being 'told what to do' by the Government is compounded by an attitude that older adults, particularly at the higher end of the age range, have lived their life and are entitled to drink as much or as little as they like. This is seen in the media, with headlines such as "*Dr Bully wants to snatch granny's sip of sherry*[64]" and "*Middle-class drinking? It's one of my favourite things*"[65]. This attitude has the danger of creating, or compounding where it exists, ageist assumptions in service providers, health professionals and policy makers that older adults do not warrant advice and help because of their age. Individuals deserve to be given the correct information to make informed choices, and the opportunity to live a healthy and happy life should not be disregarded because of age.

Conclusion

This report adds to the growing body of evidence around older adults and alcohol-related harm in the UK. Informed by existing evidence and the Drink Wise, Age Well questionnaire study, the first survey specifically looking at drinking behaviour in later life, this report gives a wide-ranging overview on the state of the nation of older adults, drinking habits and attitudes. The conclusions drawn from the report are outlined below.

There is a hidden problem of alcohol-related harm in the UK over 50s population, which could worsen as our population ages.

Prevailing assumptions in the UK associate alcohol-related harm with younger adults. However there is growing evidence that many older adults in the UK are regularly drinking amounts of alcohol which put them at risk from alcohol-related harm. The Drink Wise, Age Well study found that of the over 50s who did drink, 20% had an AUDIT score of more than 8, meaning they are either 'increasing risk' or 'higher risk' drinkers. Taking a preliminary national view, although data do not vary considerably from country to country, Scotland and Wales have higher proportions of study area respondents over 50 drinking at 'increasing risk' levels than England and Northern Ireland, whilst the Scottish study areas have a higher proportion of older adults drinking at a 'higher risk' level than the other countries.

This all supports existing evidence. In England, alcohol-related deaths have been steadily increasing in men and women aged 55 to 74 and alcohol-related mental health problems in the over 60s have increased 150% in 10 years. We must also remember, even though alcohol consumption levels are higher in younger age groups, age-specific factors mean that alcohol-related harm can have more adverse health effects, and cost more to treat, in older adults. The NHS spends more money on alcohol-related hospital treatment in 55-74 year olds than 16-24 year olds, and alcohol-related hospital admissions have been increasing more in adults aged 65+ for a number of years. In an age of dwindling financial resources and budgetary austerity, there is a danger that older adults are seen as a drain on resources and viewed pejoratively as a "burden", with them feeling that they are being blamed for the increase in admissions. The aim of this report is not to add to these negative perceptions but to highlight that older adults are being failed by Government, health and social care providers and other relevant actors when it comes to prevention and reducing alcohol-related harm.

There has been a relatively recent increase in interest surrounding alcohol-related harm and older adults, with some recent studies and campaigns in the UK highlighting the issue such as the Royal College of Psychiatrists, 2011 'Our Invisible Addicts' Report. However this problem has been ignored by too many people, for too long. Strategies from health and social care services, alcohol awareness charities and policy makers need to take into account age in their strategies to reduce alcohol-related harm. We hope this report goes some way to raising awareness and argue the need for action.

The over 50s are diverse, with different patterns of alcohol consumption and different levels of risk

Whilst general alcohol strategies cannot work without taking into consideration age, there also cannot be a blanket approach to alcohol-related harm and older adults. Consider the two survey respondent examples, 'David' and 'Betty', highlighted earlier in the report; both are at risk from alcohol-related harm, but for different reasons and in completely different life circumstances. This report has demonstrated that the over 50s are a diverse group, with different characteristics being associated with higher levels of alcohol consumption and higher risks of alcohol-related harm. Having a chronic illness or disability, living alone or without a partner and being male are all associated with being at higher risk from alcohol-related harm, as is not engaging in fulfilling activities and not coping with stresses in life. The reasons over 50s cite for drinking also vary, and

differ significantly by levels of consumption. If an older adult is of lower risk, 75% of them drink to be sociable; if someone is of higher risk, 78% of them drink to take their mind off their problems.

The report has also highlighted specific groups of older adults who may require more nuanced attention and may be at particular risk from alcohol-related harm. BAME communities may have specific cultural reasons for not engaging in service provision and health and social care services; the 'oldest old' are more likely to be frail, have dementia or a disability which can all affect degrees of alcohol-related harm and ease of accessing services; our survey and existing evidence indicates alcohol consumption is higher in older LGBT adults. All this demonstrates that a blanket approach to older adults and alcohol-related harm does many a disservice.

Older adults can often be missed by key stakeholders

This report has also highlighted that older adults can more easily be missed by groups, organisations and individuals who can detect risks of alcohol-related harm. On a macro level, Government strategies and public health initiatives often focus on younger people, such as drink driving campaigns and binge drinking posters. GPs and primary care services are often less aware of alcohol-related harm in older adults, with too much focus on actual levels of alcohol consumption rather than appreciating that age-related factors can mean that lower levels of consumption in older age can have adverse effects. Similarly, alcohol screening in hospitals and acute care are often not nuanced for age, and treatment centres for alcohol problems can have an upper age cut off and can be inaccessible or intimidating places for older adults. These stakeholders need to be looking for alcohol-related harm especially in older adults, who may be less likely to self-identify alcohol problems than younger generations; 74% of the survey respondents could not correctly identify recommended drink limits. Moreover they may be more likely to hide problems, with 45% of over 50s and 55% of over 65s thinking people with alcohol problems have themselves to blame.

Older adults, needs are often also missed by Government policy which looks to reduce alcohol-related harm. There needs to be an appreciation of the role alcohol can have on social isolation, coping with dementia and life transitions such as retirement and bereavement. Whilst there exist Government strategies for all of these, a more joined-up approach which incorporates these factors into alcohol strategies as well as alcohol strategies into these factors is needed.

Whilst Drink Wise, Age Well will be developing strategies to identify and target older adults at risk from alcohol-related harm throughout the programme, the findings from our survey begin to inform this process. Specific groups who may need specific targeting have emerged from the analysis; males, people living without a partner or living alone, those who have a chronic illness or disability and people at the younger end of the older age spectrum all are more likely to be at high risk of alcohol-related harm. The key stakeholders discussed above, who are often missing opportunities to reduce alcohol-related harm in older adults, can start to use this report to shape targeted interventions.

Drink Wise, Age Well is well-placed to meet these challenges and provide direction

Finally, Drink Wise, Age Well will throughout the programme be meeting the challenges addressed above. A strong evidence base will be built, both around the scale of alcohol-related harm in older adults and around 'what works' in terms of interventions and education programmes. Drink Wise, Age Well will be taking a preventative approach, encouraging older adults across the UK to form a healthier relationship with alcohol as they age. Findings will be widely disseminated and best practice will be shared, whilst at the same time Drink Wise, Age Well will be continuously informed by experts and older adults themselves throughout the programme.

But there needs to be increased support from a number of stakeholders if alcohol-related harm is to be reduced in older adults. There is a need for greater awareness and more action to reduce harm from policy makers at both a national and local level, health and social care services, the third sector and the wider public if Drink Wise, Age Well is to succeed. We hope this report, giving a 'State of the Nation' overview of older adults and alcohol use today, starts the process of

effecting real change across the UK.

Where next?

We are aware that we are just at the start of our policy journey. Throughout the Drink Wise, Age Well programme we will endeavour to meet these challenges and provide direction; however it is evident given the range of actors and decision-makers involved that we need to engage a cross section of stakeholders and secure leadership from across the health and social care spectrum.

What are the next steps for Drink Wise, Age Well?

Over the next five years, the priority of the Drink Wise, Age Well programme will be providing operational, frontline services on the ground in the five demonstration areas, and we will evaluate the impact of the programme, disseminating our learning as time goes on.

What are we asking from you?

As we have highlighted in this report, we want to consult and engage with a wide range of stakeholders to fully understand the journey from prevention, identification, treatment and care for older adults. Over the coming months, we will convene a high-level inquiry and call upon expert witnesses from: Government Departments, regulation and safeguarding organisations, national organisations such as Public Health England, local organisations such as local government and clinical commissioning groups, health and wellbeing boards and local health and care services. We will also engage with charities, business, journalists and wider civil society. This will be the

first step to ensure we understand the interventions that are required to improve the lives of thousands of older people at risk of alcohol-related harm in the UK today.

What needs to happen now?

We welcome the recent government revision of recommended alcohol guidelines, in particular the simplification of weekly units for men and women, with advice to take a number of alcohol-free days each week. However we strongly advocate a more nuanced approach for guidelines in relation to alcohol use and older adults.

The guidelines only refer to older adults as an at-risk group under the single episodic use section of the guidelines. However, older adults are more likely to drink regularly and every day, and even with the recommended 14 units per week recommended, may still be at more risk of health harms than younger people. Also as highlighted earlier in the report there will be huge variability, and the increased risk is likely to be greatest amongst the older old, those who are frail, those who have a health condition exacerbated by alcohol and those who are taking medications that interact negatively with alcohol. Therefore we would recommend more detailed and older-age specific guidelines as a follow on from the general population guidelines.

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