Cheers!?

A project about older people and alcohol

Lizzie Ward
Marian Barnes
HSPRC, and
Beatrice Gahagan
Age Concern, Brighton, Hove and Portslade

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University of Brighton

FOREWORD

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Further information about the Centre can be obtained from:
Sallie White, Research Administrator
HSPRC University of Brighton
Falmer, Brighton, BN1 9PH

Telephone: 01273 643480
Fax: 01273 643496
Email: s.s.white@brighton.ac.uk
visit our website www.brighton.ac.uk/sass/research

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Older people and Alcohol Steering Group:
Jim Baker, Age Concern Brighton, Hove and Portslade
Marian Barnes, University of Brighton
Angela Flood, Brighton and Hove City PCT and City Council
Beatrice Gahagan, Age Concern Brighton, Hove and Portslade
Peter Huntbach, Sheltered Housing Services, Brighton and Hove City Council
David Nicholls, Adult Social Care, Brighton and Hove City Council
Harry Steer, Older People's Council
John Patience, Brighton and Hove DAAT
Charlotte Marples, Brighton and Hove City PCT
Lizzie Ward, University of Brighton

Co-researchers:
Julie Frayne
Gill Hart
Dorothy Lewis
Bernard O'Donnell

Reference Group:
Jack Hazelgrove
Diana Owen
Liz Ray
Roderick Thompson
Francis Tonks

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Executive Summary

Introduction

Alcohol use amongst older people is a neglected area in research and in policy and practice. Although alcohol use has attracted a significant amount of government and media attention in the last decade, this has been dominated by the spotlight on younger peoples' drinking. In 2004 the government launched The National Alcohol Harm Reduction Strategy (Cabinet Office 2004) but this and the subsequent Next Steps document (Department of Health 2007) contain no specific statements about older people as the focus is on younger binge drinkers, public order and criminal justice issues. There is very restricted research about older people's experience of alcohol and because of this, their reasons for drinking and the kinds of services and responses they would like to see to alcohol related health and social problems are not well documented.

A group of agencies in Brighton and Hove led by Age Concern Brighton, Hove and Portslade and including Brighton and Hove City Council, Brighton and Hove Primary Care Trust and the Drug and Alcohol Action Team were aware of a gap in local research evidence on alcohol use by older people in the city. This research gap covers direct data on alcohol use amongst the older population, particularly those not already known to services; and on the capacity of services to be aware of and respond appropriately to the needs of older people where alcohol use is impacting on their health and well being. The agencies understood that older people's alcohol use impacts across their areas of work and recognised the need to develop a collaborative approach in developing the local evidence base and informing the longer term development of services and training. The agencies formed a steering group and commissioned the Health and Social Policy Research Centre (HSPRC) at the University of Brighton to undertake a scoping study (Smith et al 2007). This examined the experiences and perspectives of health, social care and voluntary sector professionals in order to build a picture of the incidence of alcohol use in a discrete geographical area of the city and to develop an understanding of current practitioner knowledge and approaches to the subject.

Further funding was obtained from Brighton and Sussex Community Knowledge Exchange (BSCKE) to undertake this research and build on the scoping study to generate a wider evidence base by asking older people themselves about the role of alcohol in their lives. The aim was to provide an angle that previous research has tended to neglect, namely, understanding people's life journeys as they get older, the kinds of issues they face, their problems and concerns and how alcohol may relate to these factors. The aim was to explore the circumstances in which older people drink, the meaning that drinking alcohol has for them and the impact it has, acknowledging that this can be a pleasurable and positive experience, as well as something that can have adverse health, financial, personal and interpersonal impacts.

Methodology

A major challenge of the research, given the sensitive nature of the topic, was how to approach older people and ask about their experiences of alcohol use and this shaped the design and development of the project. We developed a participative approach by involving older people in the research and aiming to break down the barriers between 'expert knowledge' and 'lay knowledge' and encouraging mutual recognition, sharing and validating different areas of expertise. We recruited co-researchers from Age Concern's volunteer base, whose main role would be to conduct the individual interviews; however, we also wanted to develop the research design as a team and expected their input as active participants in the research process. We also set up an older people's reference group to guide and stimulate the research process and offer other older people's perspectives on the topic.

Twenty individual interviews and three focus groups were conducted with people from a range of backgrounds and circumstances. Our intention was to reflect differences across age, gender, sexuality and ethnicity without making any representational claims about these different groups but rather to ensure that we had a varied and inclusive range of experiences within the data.

Key themes that emerged from the interviews and focus groups

- The participants engaged in different drinking practices and these were divided into four different 'drinking styles':

    - **1. Social – Regular**. Typically within this style alcohol was seen as something enjoyable and pleasurable. It was connected to positive social interaction and drinking was characterised by an experience shared with spouses or friends.
    - **2. Social – Occasional**. This style was similar to the first in that drinking was linked to social occasions and in particular to food or meals out but less frequently than every day.
    - **3. Heavy lone drinking**. The defining features of this style were regular drinking in larger amounts, alone and outside of social interaction with others, usually at home.
    - **4. Heavy drinking in a drinking network**. In contrast to being a solitary activity, this includes elements of social interaction and takes place in the company of other drinkers. The networks included those who were social contacts because they drink as well as friends who drink together.

- In addition to the different styles, we identified a number of themes that related to drinking practices and decisions around alcohol consumption. These themes cut across the four styles but appeared in different dimensions within each style:

- **Social relationships**. There were connections between social relationships and drinking practices which were wide-ranging and varied according to individual circumstances and within different drinking styles.
- **'Loss'**. Changes in drinking practices were explored in relation to life transitions. These included changes in relationships, work, health, housing and moving to a different area. Some of these were described in terms of 'loss' - of partners, family and friends through bereavement as well as loss of physical health and mobility, daily routines and structures.
- **Relationship between current and previous lifestyle**. There were connections to drinking practices over the life course, and the desire to maintain activities that had always been a part of one's life, but from which people may become excluded as they grow older.
- **Financial impacts**. Many participants described the cost and availability of alcohol as significant factors in their drinking practices.
- **Health, well-being and growing older**. Some participants had made changes to their drinking practices as a result of health issues.
- **Responsibility, and maintaining control and independence**. Participants made decisions about controlling the amount of alcohol they consumed and many had their own self-imposed 'rules', such as, having only one drink a day, not drinking every day, not drinking before a certain time in the day or not drinking at home.

- Participants whose drinking practices fitted the social regular and social occasional styles had not sought help and did not think their drinking patterns required any help. Generally most thought that their GP would be the first place they would go if they needed help.

- Participants whose drinking patterns fitted the two heavier drinking styles were more ambivalent about seeking help. This ranged from not perceiving their drinking as a problem at all to an acknowledgement that they were aware they were drinking above the recommended safe levels but reluctant to make any changes.

- Differences in experience that may connect to structural factors, such as gender, ethnicity, sexuality were not explored in great depth. However, cultural differences in attitudes towards alcohol were described in the Black Minority Ethnic (BME) focus group. The ways in which men and women described the role of alcohol in their lives and their attitudes towards drinking connected to wider issues of gender differences. The needs of older people which are overlooked within the general population are likely to be worse for people who are already marginalised and 'hidden' because of their sexuality.

- Developments within the city in relation to the night-time economy have created particular issues for older people and those with problematic drinking patterns. There were perceptions that certain places were unsafe for older people because of the dominant drinking culture. Leisure and social spaces are aimed at younger people and this can add to a feeling of exclusion for older people and exacerbate their fears around not feeling safe.

Implications for policy and practice

- Older people drink in different ways for different reasons. For some it is associated with pleasurable social interaction or time for themselves. In other cases drink fills an absence in their lives and may have become an activity they cannot live without. In addition there are differences in relation to experiences related to gender, sexuality and cultural background that need to be taken into account and better understood.

- Older people's drinking is affected both by their personal circumstances and biographies and by social and economic circumstances. The greater availability of alcohol and its comparative cheapness plays an important role in this.

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- It may not be useful to define older people's over use of alcohol as primarily a health problem.

- Maintaining social spaces where older people can meet others and enjoy a drink together is likely to be important for many older people. Pubs that serve good food at reasonable prices can offer a focus for social contact and 'safe' drinking. The issue of the changing nature of pubs were raised by many and the extent to which they do not appear to be geared towards attracting the custom of older people. Publicans could play an important role in providing facilities for older people. This is an issue that is relevant in the context of urban planning and local regeneration.

- Having an active engagement in activities involving others seems to play an important mediating role for those who might be tempted to drink too much. The capacity to continue to take part in a range of social activities that engage older people's interests and skills, and make them feel that life is still worth living is likely to limit the likelihood that alcohol will be used to mask loneliness.

- Older people may need to be actively encouraged to take part in activities as they may be unused to mixing, having been used to being one of a couple in social situations for much of their lives. Low key facilitation and befriending schemes may be important here. The links between older people and social exclusion have already been recognised locally and existing community development work

encouraging older people's engagement is useful in relation to alcohol issues.

- Sheltered housing and other residential facilities for older people are a potential source of social contact, but residents may still wish to maintain contact outside. Sheltered housing staff could play a key role in facilitating older people's engagement in activities that may act in a preventative way to reduce drinking.

- Professionals who have contact with older people who may be drinking heavily need to explore whether this is something the person is comfortable with and feels in control of, or whether there are changes they might like to make in their lives that would obviate their experienced need to drink heavily. Our experience of recruiting interviewees confirms that the topic has to be approached very sensitively but that it is possible to create a context in which older people can talk about their drinking and this study has shown the value of enabling older people to tell their own stories about the place of alcohol in their lives.

- GPs are important as they were most likely to be identified as first source of help. An approach that is likely to be helpful cannot simply be framed in terms of 'safe units'. There is a need to understand the context in which drinking is occurring, the role it plays in older people's lives and what might be the consequences of stopping drinking.

- Older people's rights to make their own decisions about how they live their lives needs to be balanced by an ethic of care that recognises vulnerable people may need help to determine how their needs might best be met. An approach applying ethic of care principles: *attentiveness, responsibility, competence, responsiveness* and *trust*, to a process of dialogue with the older person concerned has the potential to enable the exploration of a difficult issue, and a shared decision-making approach to seeking solutions.

1. Background

An 'Age Concern' concern?

Since at least as far back as 2001 there has been a general recognition within the Age Concern Federation that the subject of alcohol use amongst older people is a neglected area both of research and in policy and practice. Despite attracting a significant amount of government and media attention in the last decade, the focus on alcohol has been largely limited to younger people. In 2004 the government launched *The National Alcohol Harm Reduction Strategy* (Cabinet Office 2004) but both this and the subsequent *Next Steps* document (Department of Health 2007) contain no specific statements about older people as the focus is on younger binge drinkers, public order and criminal justice issues. Although the *National Service Framework for Older People* (Department of Health 2001) highlights the issue it does not set any specific targets relating to older people and alcohol use.

Available research has been mainly quantitative and conducted in America. There has been a limited amount of research carried out at a local level in the UK. Age Concern Wandsworth (2002) initiated and managed an inter agency project which highlighted issues and concerns both amongst professionals in Health and Social Care and individual older people and their carers about alcohol use in the area. They identified that 2.3% of regular drinkers and 6.5% of those who engage in hazardous drinking levels are aged over 65. Third Sector First conducted a study in Ayrshire and Aran (Clough et al. 2004) which suggested that alcohol use in older people is an area which professionals are reluctant to approach in any direct way. It was generally felt within the Age Concern England Research and Development Unit (ACE R & D unit) that more information across a wider area was needed.

'Not much of a problem or we'd rather not talk about it: Older people and alcohol'

The unit commissioned a research paper in 2004, consulting with twenty two local Age Concerns across the country (Bright 2004). The responses provided some valuable insights about a lack of any specific services or service partnerships relating to older people and alcohol. It highlighted the fact that many local Age Concerns were providing support to older people that could indirectly address issues relating to alcohol use, such as social isolation, anxiety about financial matters, difficulties relating to transitions in later life and the general loss of control, but there was little specialist work directly addressing alcohol use. Discussions with the Age Concerns who took part in the survey reflected a general feeling of dilemma about alcohol use in old age: on the one hand being aware of the vulnerability of some older people and the need to provide support, while on the other hand not wanting to impose

judgement on them, of respecting their privacy, autonomy and choices even if these put them at risk. This tension between rights and risks and how these are understood and interpreted by social care providers has also been highlighted in other research which looked at these issues in relation to local authority practice (Herring and Thom 1997).

The Age Concern research paper suggested that several factors have contributed to a general under diagnosis of drinking problems in older people. These include the desire to respect individuals' choices; the fact that it is harder to assess problem drinking in later life because of the presence of other symptoms that can mirror the affects of alcohol, and that there is little or no specialist service provision for older people with alcohol problems. Age Concern England concluded that:

> *There is still too little evidence available to support the call for substantial resources to be diverted to this area of work (2004, p.25).*

However, in their subsequent Research Briefing *Not much of a problem? Older people and alcohol* (2005) they point to information produced by Alcohol Concern suggesting that safe drinking levels for older people may be considerably lower than for those in younger age groups, and that the reduced tolerance to alcohol in old age can amplify risk factors, alongside complicating factors such as medication (Alcohol Concern 2002, 2004; Waller et al 2002).

Brighton and Hove

Age Concern Brighton Hove and Portslade (ACBHP) developed an interest in the subject in 2001 when the organisation was approached by a retired consultant psychiatrist who had been a leading figure in tackling alcohol problems in the area. He felt that there were a large number of older people with undiagnosed alcohol problems in the area and approached Age Concern Brighton with a view to designing a research protocol. Owing to a lack of available resources at the time the research was put on hold, until the interest was taken up again around 2006.

The Steering Committee - different interests and perspectives

Within Brighton and Hove there is no dedicated service for older people who may have problems with alcohol or would like to seek some help. The acute services that do exist are for those at the more extreme end of the spectrum of alcohol use and are not always suitable for the needs of older people because of the geographical location and access or because they are predominantly used by younger people. The gap in local research evidence covers direct data on alcohol use amongst the older population, particularly those not already known to services; and on the capacity of services to be

aware of and respond appropriately to the needs of older people where alcohol use is impacting on their health and well being.

With some lobbying on the part of ACBHP, support for a research project was included in the original delivery plan for the Local Area Agreement in Brighton and Hove. A Steering group was formed led by ACBHP and included representatives from Brighton and Hove City Council's Adult Social Care and Sheltered Housing Teams, Brighton and Hove Primary Care Trust and the Drug and Alcohol Action Team.

By involving key stakeholders in the steering group the research project was intended to have a built in connection to the key strategic and policy development discussions and partnerships for the city - especially important for the Health and Social Care Programme Board, the Healthy City Partnership and Local Strategic Partnership. The various agencies had different interests in the project reflecting their particular professional background and perspective:

- For the Local Authority's 'Community Programme' the research focus would link with concerns to develop better, more preventative services for older people, improve quality of life and address social inequalities and social exclusion. Research could provide a better informed picture of older people's use of alcohol and links could be made with the development of user involvement/consultation in transforming public services. Specifically in relation to Adult Social Care the shift towards personalised budgets and self-directed care implies a need for these issues to be understood by service providers and the Older People's Commissioning Strategy.

- The local Drug and Alcohol Action Team had been aware of issues relating to older people but historically there had been a lack of resources to pursue further work in the area. The research would provide an opportunity to gain a greater picture of older people and alcohol use and possible methods of intervention that could be helpful. In particular, it could link to the Responsible Authorities Partnership /DAAT Alcohol Gaps Strategy 2005/08 for the city which specifically commits to 'Investigate the problems facing elderly people who drink at harmful levels'.

- From the health perspective there was interest in investigating the concern that alcohol may be a factor in accidents, falls and in related diseases and to assess the impact of alcohol use in older people in relation to health and cost implications. In addition, there were links to the Healthy Cities initiative and the local shift in thinking and investment into preventative, community based responses to need and the key public health responsibility for the promotion of health and raising awareness of health problems of older people.

- From the housing perspective Brighton and Hove City Council is a significant housing provider for older people in both sheltered and non-

sheltered housing within the city. There were concerns locally about the impact of older people with alcohol problems on housing issues (in particular, for sheltered housing), and for safety in the community.

- For Age Concern the interest linked to understanding local and national policies and strategies on the Healthy Ageing agenda and development of preventative services for, and the involvement and empowerment of, older people. This included actively involving older people in the research and working with older people themselves as researchers.

The scoping study

The steering group were aware that older people's alcohol use impacts on a number of agencies and therefore, recognised the need to develop a collaborative approach in developing the local evidence base and informing the longer term development of services and training. They commissioned a scoping study from researchers at the Health and Social Policy Research Centre at the University of Brighton (Smith et al 2007). This examined the experiences and perspectives of health, social care and voluntary sector professionals in order to build a picture of the incidence of alcohol use in a discrete geographical area of the city and to develop an understanding of current practitioner knowledge and approaches to the subject.

The scoping study gathered quantitative data from a number of local and national sources. The local data related to alcohol use amongst older people was somewhat difficult to uncover and the researchers experienced difficulty particularly with some health data. The data that was available indicated that the area studied contained significant numbers of pensioners in 'lifestyle groups' who were considered to be at an increased risk of hospital admission for alcohol related conditions.

Secondly, the study gathered qualitative data from interviews with a variety of agencies. Participants were asked about the incidental use of alcohol in older people, and the capacity of services to respond to alcohol related needs. The perceptions of the practitioners and staff included:

- That an estimated average 10-15% of their current user base of older people had some problem with alcohol and awareness of the impact of increasing alcohol use both on individuals and on agencies.

- The recognition of two distinct groups of drinkers within their user base. The first (generally younger) group comprised those with long term and often diagnosed alcohol problems who were known to agencies. The second group, who were less known about and often more isolated, became known though their need to access services as a result of acute events.

- That older people in general are very private about their problems and how they deal with them and very much less obvious in their drinking habits.

- That older people may be socially isolated, drinking 'behind closed doors', particularly women, who are more likely to be solitary drinkers and more discrete in their drinking.

- That societal perceptions about use of alcohol and older people in general played a strong role in how the issue is seen and dealt with. These included the 'invisibility' of older people which means they are treated poorly on all issues, and a view that there is little point in intervention as older people are unwilling to change habits.

- That many of the reasons for high or excessive alcohol use amongst older people were also common to other age groups, such as social reasons or to avoid facing up to difficulties. However there were specific reasons relating to sudden and debilitating life changes, metabolism changes due to ageing, decreasing health and mobility, bereavement, loss and depression that were particular triggers for older people.

In general staff and practitioners did not feel they identified alcohol issues amongst older people as well as they could as they were often hidden by acute symptoms and masked by other health conditions or medication. Alcohol problems whilst often identified at a crisis point were seen very much as a long term community care issue. The main issues for staff were:

- difficulties in knowing how to approach the issue with older people

- the inability of many older people to accept or acknowledge that they have a problem

- lack of appropriate services for referral

- problems related to accommodation

The scoping study also corroborated previous research which suggested that practitioners do not feel they can effectively identify or address alcohol problems in older people (Clough et al 2004). Staff saw a number of barriers to dealing effectively with alcohol problems amongst older people. They were particularly aware of the complexity of the issue for individuals which could involve acute health problems, mental health issues, social isolation and the need for ongoing care and support. In general staff felt they needed more training and awareness specifically around older people and alcohol. Current services were viewed as insufficient as there was no specific focus on older people particularly in the acute alcohol services and a need for more appropriate counselling and support services including an increased role for education and information support specific to older people.

Clearly the scoping study highlighted a range of different impacts on services and highlighted the need to develop a collaborative approach to gaining further evidence and knowledge to inform the development of future services. This mirrored Age Concerns' R & D unit report which suggested that:

> *Age Concerns are not well placed to provide specialist services but that other specialist agencies could improve their expertise in older people/alcohol issues...' and that 'there is scope for better multi-agency working between specialist alcohol services and older peoples organisations* (Age Concern England 2005, p.4).

Cheers!? A project about older people and alcohol

The scoping study formed the basis of a larger bid to obtain funding from Brighton and Sussex Community Knowledge Exchange (BSCKE) for a partnership project involving the agencies identified above and carried out via collaboration between the University of Brighton and Age Concern. BSCKE funded projects involve a partnership between the university and community stakeholders and a commitment to exchanging knowledge and learning from the process of working collaboratively (appendix 1). The purpose of this research was to build on the scoping study and generate a wider evidence base by asking older people themselves about the role of alcohol in their lives. The aim was to provide an angle that previous research has tended to neglect, namely, understanding people's life journeys as they get older, the kinds of issues they face, their problems and concerns and how alcohol may relate to these factors. A key theme in the proposal was that older people should be trained to carry out the research with the dual purpose that it would be beneficial for them personally in terms of developing further skills and would also create expertise which could be drawn on in other community research projects. As we describe later in the section on our research methods we felt that it might also be more effective for older people to be interviewed by people more similar in age.

Geographical, economic and social context

The original intention was to focus the study in two areas of Brighton and Hove which have a high concentration of older people and where there are high levels of deprivation. As we discuss further below, this place based focus was questioned during the course of the project – in part because of the difficulty of recruiting participants in one of the areas and the wish not to exclude those willing to take part who did not live in these areas. But we also recognised that where alcohol use is a problem this is not restricted to older people living in deprived circumstances.

The discussions of the Steering Committee focused most attention on understanding older people's drinking patterns, and less on the nature of the local economy and cultural norms which might affect drinking habits. However, the approach taken by the research was to try and understand drinking not just in terms of the meaning for individuals, but also in terms of its social and cultural context. The questions we asked have tapped into some significant contextual factors such as the availability of alcohol, changes in licensing laws, the marketing of alcohol, as well as the impact of reduced social contact and recognised roles for older people and although not a primary focus of the research, these issues were reflected in the older people's accounts.

Other studies have taken a geographical perspective, although not specifically in relation to older people (Thomas and Bromley 2000, Valentine et al 2007). Valentine et al (2007) for example, have highlighted the significance of place in affecting drinking patterns and Thomas and Bromley (2000) have looked at the impact of the development of the night-time economy in city centres on negative perceptions of safety. These are issues that are particularly relevant to Brighton and Hove as a city with a highly developed leisure and entertainment industry. Whilst we can offer some reflections on aspects of the spaces and places in which older people drink, and the impact on older people of local drinking cultures, we would suggest that this is worthy of further study in its own right.

Approach

The scoping study confirmed the very limited amount of research that has considered drinking amongst older people. It also provided insights into the way in which those who work with or come into contact with older people (including the police, the ambulance service, mental health service providers, sheltered housing providers, social care workers, voluntary sector workers, substance misuse workers and others) have come to identify alcohol use as a 'problem' amongst older people. The purpose of this follow up study was to learn about how older people themselves think about their use of alcohol, the place it has in their lives and the impact it has on them.

The Issue

There was considerable discussion amongst members of the steering group and amongst the researchers about how we should describe the topic – to those we were inviting to take part in it and to others with an interest in the subject. We decided against the use of terms 'abuse' or 'misuse'. This was not only because we thought it would be hard to encourage people to come forward to be interviewed if we described the purpose in this way, but more importantly, because we did not assume that the use of alcohol amongst older people was inevitably a problem. We recognised that drinking may be

pleasurable in its own right, be a means of sustaining social contact, and also that it might be used in circumstances where losses had created a hole to be filled. In none of these circumstances would it be helpful to refer to the abuse or misuse of alcohol.

This had obvious implications for the definition of those we hoped to include in the study. It was not designed to engage older people who were already in receipt of services specifically related to alcohol misuse. Rather the aim was to identify people who regularly drink alcohol for whom it may, or may not be a problem. We describe below how we went about identifying such people. Our aim was thus to explore the circumstances in which older people drink, the meaning that drinking alcohol has for them and the impact it has, acknowledging that this can be a pleasurable and positive experience, as well as something that can have adverse health, financial, personal and interpersonal impacts.

Alcohol and Ageing

Because of this we did not locate this study within the literature on addiction or alcohol abuse. We had already established that there is little such literature specifically addressing the experiences of older people, and it did not seem appropriate to draw on that relating to younger people. We subsequently identified an unpublished literature review *Problem Drinking and Older People* undertaken by Davidson and Ginn (2005) which confirmed the dominance of medical research and an increasing body of literature within the health promotion and health education arenas, but little that takes a holistic approach to understanding older people's drinking behaviour in the context of social, cultural and economic circumstances and which recognises the way in which 'socially constructed roles shape behaviour throughout the life course' (ibid, p.3).[1]

Our approach has thus been to understand alcohol use within the context of older people's lives as they are currently lived, and to recognise the impact of the changes that people go through as they age in contributing to current drinking patterns. In this context we have sought to ensure that participants in the study include older women and men, living on their own and with others, from different ethnic and cultural groups, and who identify themselves differently in terms of their sexuality. (We discuss how successful we were in including different older people in the study in the Methods section). Critical gerontology (eg Bernard and Scharf, 2007; Estes et al, 2003) recognises the need to examine the structural inequalities that influence the experience of old age as well as understanding the personal experiences of older people in the context of individual and shared biographies. Whilst we did not sample in order to test the significance of different socio-economic variables in relation

[1] As an exception see Clough, R., Hart, R., Nugent, M., Fox, D. and Watkins, C. (2004) *Older people and alcohol. A summary and recommendations arising from research in Ayrshire and Arran.* Lancashire: Third Sector First.

to older people's drinking, we have sought to understand the stories people told us about their drinking in the light of what we know, for example, about the different ways in which women and men experience ageing (Bernard et al, 2000, Davidson, 2004) and to consider what these stories have to say about other aspects of inequality in old age.

The category 'older people' is problematic not only because of the differences we have alluded to above, but also because 'old age' encompasses a broad period of time and people who belong to different cohorts in terms of age and generation. Recognition of this has led to an emphasis on ageing rather than old age in gerontology and we adopted a similar perspective. Thus we sought to include in the study people aged 50 and above, which reflects Age Concern's remit and enabled us to consider the experiences of people who are growing towards the point at which they become officially defined as 'old'.

Older People's Narratives

The other main aspect of our approach in this study is a methodological one. We discuss the ways in which we went about involving older people as co-researchers and as members of an older people's reference group in the next section. One objective of the study was to contribute to the development of a team of older researchers who might subsequently also work on other projects. But as well as the decision to undertake research with older people in this study our approach also emphasises the importance of older people as narrators of their own stories and interpreters of their own lives – as 'active subjects' as one of us has written elsewhere (Barnes and Taylor, 2007). Thus we wanted to enable older people to speak about their experiences of drinking in ways that made sense to them and to construct their own ideas about the place of alcohol in their lives, rather than responding to pre-defined assumptions about, for example, recommended weekly limits in terms of units of consumption. This meant that the interviews that were undertaken adopted a broad structure within which to encourage people to talk, rather than comprising a list of specific questions to which we were asking people to respond.

2. Methods

Research design and carrying out the study

A major challenge of the study, given the sensitive nature of the topic, was how to approach older people and ask about their experiences of alcohol use and this shaped the design and development of the project. In addition, there were a number of elements that needed to be taken into account which underpinned the philosophy of the project:

- The desire to work collaboratively and develop our partnership.
- To place the experiences of older people at the centre.
- To involve older people in designing and conducting the research.
- To be reflective in our approach to the topic and the research processes.
- To develop and build good practice for this type of research project.

Original research design

As the project evolved the original design changed in two ways. As we discuss in the following sections, a key aspect of the project has been working collaboratively as a team and part of building our partnership led to substantial re-thinking of the research design. Initially the intention was to run focus groups early on in the project to discuss general questions about the use of alcohol and the positive and negative effects it has on older people's lives. The issues raised from the focus group discussions would then be used to inform the content of in-depth individual interviews. It was hoped that the focus groups would also generate awareness of the project and be helpful in recruiting participants for the individual interviews. However, we wanted to involve the co-researchers from the outset in the development of the research design and on a practical level it would not have been possible to involve them in the focus groups had we run them early in the project. We therefore prioritised recruiting the co-researchers in the early stages of the project and then working as a team we reviewed our approach to the focus groups and individual interviews. As we go on to discuss, we developed the content of the individual interviews during our training sessions with the co-researchers.

We used the focus groups in a different way to how we originally intended. During the course of the research alcohol consumption received a lot of media attention following several reports of increases in the levels of drinking and associated health and public order problems. We became aware that the high

media profile may be having an impact on both how we as researchers may be reacting to the topic and also how our participants may talk or think about the topic. We decided to explore this within focus group discussions.

Secondly, the project was to concentrate on two geographical areas of the city. These had been identified within Brighton and Hove City Council's Local Area Agreement as target areas for piloting neighbourhood programmes to deliver health and well being services and opportunities for older people. They also contain a significant number of people over 55, many of whom are living alone. It was hoped that by linking the project to the local authority priorities the potential impact of the research findings on the development of services would be increased. However, during the course of the project, the local authority reviewed its priorities and the significance of these two areas lessened. We were concerned that we may exclude potential participants with valuable experience to contribute by focusing on just these two areas. From the experience of our health colleagues on the steering group we were also aware that alcohol misuse is an issue that cuts across class and income and is not just a problem that affects working class communities. In addition, one of the areas proved rather difficult to recruit participants, as we discuss below. We therefore later expanded the geographical focus across the city.

First steps: building our partnership

One of the significant features of this project has been the coming together of stakeholders from different organisational backgrounds and interests to work collaboratively. We spent time planning the initial stages and establishing our working relationships to take account of both the needs of the research and our own organisations' working practices. In practice, taking a collaborative approach and involving others in the research requires building trust and rapport to overcome any institutional barriers to working outside of 'usual' working arrangements.

The second significant feature was involving older people in the research and breaking down the barriers between 'expert knowledge' and 'lay knowledge' and encouraging mutual recognition, sharing and validating different areas of expertise. To meet this aim the early stages of the project involved the recruitment of the co-researchers and an older people's reference group. The main role of the co-researchers would be to conduct the individual interviews; however, we also wanted to develop the research design as a team and expected their input as active participants in the research process. Similarly, the older people's reference group would guide and stimulate the research process and offer other older people's perspectives on the topic.

After discussion we agreed a role description and recruitment process for the co-researchers to be recruited through Age Concern's volunteer base. We also produced some information on the role and expectations of the reference group. From the very beginning we felt it was important to be clear about issues such as time commitment, time scales, training, the nature of the topic

and what support we could offer. Having established these principles we publicised the project and the opportunity to get involved as co-researchers or members of the reference group through Age Concern's volunteer database and wider older people's networks within the city (appendix 2 and 3). We subsequently recruited four co-researchers and six reference group members. Three of the co-researchers were already Age Concern volunteers and the fourth worked with a pensioners' forum. They came from different professional backgrounds: social work, counselling, IT systems management. Three had had some prior experience of interviewing from their work lives and one had been involved in a research project with older people previously. They were all in their mid fifties to early sixties and three of the four were women. The members of the reference group included two women who were very experienced long-term Age Concern volunteers, one was a retired magistrate and social worker and the other had worked for over twenty years as an Advice and Information Officer, a member of a Black Minority Ethnic (BME) elders group and two former local councillors who are now members of the Older People's Council.

Developing the research as a team

Previous studies that have involved older people as researchers have reflected on the considerable contribution that older people can bring in terms of their life experiences and skills developed during their working lives (Barnes and Taylor 2007, Clough et al 2005). This was certainly the case in our project and something we wanted to take into account in developing the research and in constructing a tailored and appropriate training programme. It was clear that a conventional approach to research training covering different technical aspects of research, such as discrete sessions on interviewing skills was not appropriate. Secondly, because of the nature of the topic matter and our intention of taking a reflective approach to the subject we wanted to develop the research questions and ways in which to approach the participants as a team. Prior to this, however, we all undertook a general induction on Age Concerns policies to ensure that we would comply in areas such as confidentiality and anti-discriminatory practice. These policies, however, correspond to ethical approaches within research practice so were a useful introduction which we could later relate and apply to the research setting. Over a series of sessions we discussed what we were trying to understand in relation to older people's use of alcohol and the ways in which we could approach the topic by drawing on the skills and experience of everyone - co-researchers, the community supervisor and university researchers. The university researcher conducted a pilot interview prior to the training and this was used to inform our discussions on some of the challenges in qualitative interviewing, specifically in relation to the topic of alcohol use. From these training sessions we produced a topic guide to use in the interviews which included prompt questions to encourage discussion on the place of alcohol in the participants' lives and to give some structure to the interviews (appendix 4). The notes taken during the sessions were later assembled into a training

manual covering ethics, research relationships and technical skills for the co-researchers to refer to during the course of the interviews (appendix 5).

Ethical approval and ethics in practice

The ethical concerns raised by this project were discussed from the early stages by the steering group who highlighted the issues we needed to address given that some of the participant group may be vulnerable and the potentially distressing nature of the subject. We were also aware that the co-researchers could be affected by the interview process and that it would be important to provide support from the university researcher during the interview stage and offer de-briefing sessions. A key risk for the participants that we needed to address was that we were asking them to reflect on a sensitive topic which may involve painful memories or raise difficult issues about their current situation. It was clear that the ways in which we gained consent from the participants and where and how the interviews would be conducted needed to be carefully considered.

Initially these issues were considered in the applications for ethical approval from the University Faculty ethics committee and the local authority research governance for social care and housing. We were then able to discuss putting the procedures into practice with the co-researchers during the training. In producing the information about the research for potential participants we paid attention to the language and explaining the confidentiality (appendix 6). The usual research practice of an unqualified assurance to uphold the participant's anonymity and maintain the confidentiality of the interview material raised a dilemma for this project. Age Concern works within the local multi-agency agreement on the protection of vulnerable adults and this covers disclosure of information on their clients under certain circumstances where the client is considered at risk. We therefore had to make it clear that the interview would be confidential to the researchers unless the information raised serious concerns about the safety and well-being of a vulnerable person in which case we would need to contact somebody who could help.

The other main issue that arose in the particular context of this project, but which is common to research of this type, concerned participants who do become distressed as a result of taking part in the research. To deal with this possibility we produced information on agencies that could offer support to the participants post-interview which would be offered to the participants at the end of the interview. But as researchers, at the same time we had to be clear that our role was not to make referrals. At times this felt quite a challenge for the co-researchers because, in their other Age Concern roles, they were used to offering advice or counselling and so had to control their 'instinct' to help.

After the interview, the participants were sent a summary as a way of checking that we had understood the issues they had raised and to give them opportunity to comment. They were also given a voucher to thank them for their contribution and sharing their experiences with us.

Working with the older people's reference group

The second way in which we wanted to involve older people in the research was as members of a reference group. This group met with the researchers to assist in developing the content of the research and act as a 'sounding board' as the work progressed. We recruited members to this group by publicising the research and the role of the reference group, through Age Concern's database, other older people's groups and the steering groups' networks. We held an initial meeting for those who expressed interest where we discussed the role of the group in more detail and agreed the terms of reference (appendix 7). Six people subsequently joined the group and we met five times during the course of the research. At each meeting the group discussed aspects of the research; this ranged for example, from strategies for finding participants for the interviews and focus groups, commenting on publicity materials and the topic guide to discussing the themes that emerged in the findings. The members of the reference group also assisted in finding participants for the study by distributing information through their own networks of older peoples' groups as we detail in the next section.

Finding participants

We anticipated that finding participants may be difficult in view of the topic and the stigma associated with having a 'drink problem'. After discussion with the co-researchers and reference group we agreed on the title and images for the flyer (appendix 8) which we felt conveyed the aims of the project in a non-judgemental way, thus hoping to attract a range of people and drinking practices. The flyer was widely distributed through the steering group member's networks, sheltered housing schemes, day centres, community projects, residents' newsletters and Age Concern's database. The university researcher also visited sheltered housing schemes during coffee mornings and residents meetings to talk about the research and explain what an interview would involve. She also met with staff who worked with older people in day centres and community outreach to let them know about the research and ask for their help in publicising the flyer within their work settings.

The responses to participate in the research varied and although we cannot comment precisely on responses to the flyer the experience from meeting face-to-face at coffee mornings suggested that generally people were quite apprehensive and initially, at least, felt that 'alcohol problems' were the preserve of the young and not relevant to older people. How the topic was introduced to the residents was quite important. In one scheme, the flyers had been left on tables for the residents coffee morning and the researcher was introduced as someone who had come to talk about alcohol problems. It became clear that this had made the residents uneasy about picking up the flyer or talking to the researcher. Those who did made a point of saying they didn't have a problem but suggested particular residents who should be spoken to. In contrast, when the researcher was invited to a residents meeting

in another scheme, she was able to explain at the outset the aims of the research, the response was much more receptive and residents openly asked questions about the research and what taking part would involve. As a result of this meeting one of the residents did take part in an interview.

There was also a contrast in the responses in the two geographical areas we had originally intended to focus on. One, which has a high proportion of the city's sheltered housing schemes, and where the flyer was widely distributed via the residents newsletter, generated a lot of interest in the project and we were able to recruit ten participants. It proved more difficult to engage with people in the other area and attempts to meet with older people's groups with a view to discussing the research and finding participants were unsuccessful.

However, the recruitment strategy was successful to the extent that we carried out twenty interviews and ran three focus groups with people from a range of backgrounds and circumstances. (The demographic details of the participants are discussed more fully later). Our intention was to reflect differences across age, gender, sexuality and ethnicity without making any representational claims about these different groups but rather to ensure that we had a varied and inclusive range of experiences within the data. With regards to gender and age we achieved a reasonable balance within the interview participants but this was not the case in terms of ethnicity or sexuality. We decided to try and address the issues of inclusion and diversity through targeted focus groups, again with limited success, and one of our three focus groups was with a BME elders group. Of the other two focus groups, one was a mixed group of older people who attended a day centre and the other was a women-only group who were found via a women's project. We reflect more fully on the 'gaps' in our data in the later findings section. We were aware from previous research (Browne and Lim 2007) that Brighton and Hove has a substantial gay population and wanted to ensure that gay older people's experiences were included in our project. However, in practice this proved difficult and although we were not able to run a focus group we held conversations with an elder activist around possible reasons for non participation and some of the particular issues that relate to older gay men and alcohol.

Analysis

The process of analysis started with feedback sessions with the co-researchers where we captured their reflections and impressions from the interviews. Working together as a team we were able to discuss issues that emerged in each interview and start to highlight commonalities and differences in the data. We could begin to see how the participant's responses to an issue or situation could be contextualised within their own individual biography. The initial impressions of the themes emerging from the data were also discussed with the older people's reference group and with the partners of the steering group.

The university researcher continued the task of drawing out the key themes from the interviews and focus groups which had been recorded and transcribed. We continued working as a team by discussing the ways in which we would organise the themes in the data and the presentation of the findings. These are discussed in detail in the next section.

3. Findings

In this section of the report we look at the findings from the interviews and focus groups. In the focus groups we discussed general attitudes towards alcohol and alcohol use among older people. In the individual interviews personal experiences were explored by looking at the context of where, when and how the participants use alcohol to increase our understanding of the meaning of alcohol in older people's lives. Before we go on to describe the themes and issues raised in the interviews and focus groups we outline here the characteristics of the interview participants in terms of their ages, gender and the living circumstances together with the numbers and gender of those who took part in the focus groups. As previously described, participants were recruited through 'opportunistic' sampling by using the flyer. It should be noted here that our sample is not representative in terms of demographic features of the local older population. We cannot, therefore, generalise from our sample given its limitations in relation to diversity, geographical location or social class.

Profile of interview participants

Including one pilot interview, twenty one older people participated in the interviews. Brief biographical details of the participants are given in the appendices and the names of the participants have been changed (appendix 9).There was an even spread across age, with slightly fewer in the oldest grouping. In each of the age groups, apart from the 70 -79 range, there was an even mix in terms of gender (table 1).

Age	Male	Female	Total
50 – 59	3	3	**6**
60 – 69	2	3	**5**
70 - 79	6	-	**6**
80 - 89	2	2	**4**
Total	**13**	**8**	**21**

Table 1 Age and gender of interview participants

Just under half of the participants were married and lived with their spouses, including five out of the eight women interviewed. Two of the men and two of the women were widowed and six of the men were divorced, separated or single (table 2). This meant that three of the women and eight of the men were living on their own.

Civil status	Male	Female	Total
Single	2	-	**2**
Widowed	2	2	**4**
Married	4	5	**9**
Partnered	1	-	**1**
Divorced	3	1	**4**
Separated	1	-	**1**
Total	**13**	**8**	**21**

Table 2 Civil status and gender of interview participants

Fewer people in the younger age ranges lived on their own: three participants between fifty and sixty nine compared to eight participants between seventy and eight nine. All four participants in their eighties lived alone (table 3).

Living arrangement	50-59	60-69	70-79	80-89	Total
On own	1	2	4	4	**11**
With spouse	4	3	2	-	**8**
With others	1	-	-	-	**1**
Total	**6**	**5**	**6**	**4**	**21**

Table 3 Living arrangement and age of interview participants

In relation to housing, eight of the participants, including six female, lived in their own property. None of the women lived in sheltered housing compared to almost half of the men (table 4). Over half of the sample lived in social housing (provided by local authority or housing association) and this possibly reflects the more successful recruitment of participants in areas of the city that have a high proportion of the sheltered housing schemes. Four out of the six men who were in their seventies lived in sheltered accommodation (table 5).

Housing	Male	Female	Total
Own home	2	6	**8**
Rented – local authority	4	1	**5**
Rented – housing association	-	1	**1**
Sheltered – local authority	5	-	**5**
Sheltered – housing association	1	-	**1**
Hostel	1	-	**1**
Total	**13**	**8**	**21**

Table 4 Housing and gender of interview participants

Housing	50-59	60-69	70-79	80-89	Total
Own home	2	2	1	3	**8**
Rented – local authority	3	1	1	-	**5**
Rented – housing association	-	1	-	-	**1**
Sheltered – local authority	-	1	3	1	**5**
Sheltered – housing association	-	-	1	-	**1**
Hostel	1	-	-	-	**1**
Total	**6**	**5**	**6**	**4**	**21**

Table 5 Housing and age of interview participants

Sixty percent of the participants were retired, with only one person still engaged in full time work and two who worked part time. Three of those under retirement age were receiving Incapacity Benefit and one was unemployed (table 6).

Work status	50-59	60-69	70-79	80-89	Total
Incapacity benefit	2	1	-	-	**3**
Semi-retired	-	-	-	1	**1**
Retired	-	3	6	3	**12**
Unemployed	1	-	-	-	**1**
Working full time	-	1	-	-	**1**
Working part time	2	-	-	-	**2**
Carer	1	-	-	-	**1**
Total	**6**	**5**	**6**	**4**	**21**

Table 6 Work status and age of interview participants

Focus groups

In total nineteen people participated in three focus groups. In both the mixed gender groups there were five women and two men (table 7).

Focus Group	Male	Female	Total
Day Centre	2	5	**7**
BME elders group	2	5	**7**
Women's group	-	5	**5**
Total	**4**	**15**	**19**

Table 7 gender of focus group participants

What do older people think about alcohol generally?

In general, most of the participants expressed their awareness of the 'problem' of binge-drinkers and referred to the coverage the issue had received on TV and in the newspapers. Without exception they considered this to be a problem associated with young people. This is perhaps unsurprising given the nature of media coverage at the time the interviews and focus groups were conducted (BBC 2008, Hill 2008, Hope 2008). When we explored this issue a number of views were voiced:

It's a new problem

The visibility of younger people drinking (and being seen drunk) in public was not something that participants could relate to their own youth. Although many talked about their drinking practices being different when they were younger, for example, relating stories of occasions when they had once had too much to drink, or referring to having drunk more as younger people, there was a general feeling that things were different today. This was expressed in terms of drinking being more visible, that younger people had more money to spend on alcohol than they had in their youth and that leisure and entertainment was not focused around heavy drinking when they were young.

Some participants, who felt that drinking had been part of their youth and 'people have always drunk', also had the perception that there was something different about current drinking practices.

> *I remember years ago because it was a rough area where I come from, the Elephant and Castle... the kids would wait outside the pubs. They would wait outside the pubs waiting for their family to come out and then there'd be a lot of fights, there'd be a lot of fights then. What beer would do to people! It's always been there but it's got worse.*
> (Bob – day centre focus group)

Young women's drinking

This was seen as particularly 'new' and 'different' to their own experience of being younger. Several of the participants felt quite strongly about women drinking in that they found it distressing and shocking to see young women drunk and behaving in the same way as young men.

> *Something which disgusts me is to see young women who go out and get involved in binge drinking. I don't know whether these young people grow up to be alcoholics later on or whether they manage to overcome this through later relationships which put responsibility on them. But I think it is a problem as far as the young people are concerned and it's very distressing to see that the ladies are following the same steps as the young men. Drinking pints of beer, in the pubs you can see this.*

(Clive- BME focus group)

Anti-social behaviour

There appeared to be a connection for some of the participants between young people's drinking and public disorder and some felt it was a threat for older people's security and spoke about areas of the city that they would not feel safe going to at certain times because they expected younger people to be there drinking.

But they (older people) *get affected by youngsters who drink and break in their homes and all this sort of thing. That's the sort of things that get elderly people scared about drinking and, you know.*
(Betty – day centre focus group)

As far as it was possible to ascertain these views were based on media reports rather than personal experiences of younger people (although one focus group participant had actually been physically threatened by two younger people who had been drinking).

Now you see them with bottles of vodka and bottles of whisky drinking it out of the bottle on television don't you?
(Joan - day centre focus group)

Social and cultural changes

There were connections made by participants between current drinking practices in younger people and wider changes in society. Many spoke about the greater availability and accessibility of alcohol in addition to changes in work and family structures which had impacted on lack of control and authority over children as possible explanations of the rise in younger people's problem drinking. Many made reference to their own childhood and upbringing as important factors contributing to their attitudes towards alcohol, and to their own behaviour as young people. There were also references to moral codes of conduct or what was seen as acceptable behaviour when they were growing up and the influence of their parents, in particular, their father's 'strictness' and attitude to drinking.

I think in the years I grew up it was drummed into us by my father, he wouldn't allow drink in the house because his father drank a whole farm away and he used to go to the pub in the horse and trap, go in, get absolutely sozzled, come out, pass out in the trap and the pony used to take him home.
(Doreen – day centre focus group)

Because the parents aren't there to look after the children, they're all out working to make ends meet. They're what I call latchkey kids, they've got

a key, they go in, get what they want and they're out and that's why there's so much trouble.
(Betty – day centre focus group)

But then we all had more parental control than now, we did. I mean if you done something at school and you got the strap or got the cane, you'd go home and tell your mum, she'd say there's another one for getting it.
(Bob – day centre focus group)

Older people's drinking

In relation to older people drinking, generally it was not perceived to be a problem. The members of the day centre focus group felt that most older people only indulged in social drinking as part of special occasions:

I'm not a drinker but sometimes if someone has a birthday here we do have a drink now and again in moderation. Yeah but not into excess. We don't go into excess.
(Bob – day centre focus group)

In the women's focus group there was a discussion around life transitions for women as they get older and how this might affect drinking patterns. Some of the women felt that as they got older and their responsibilities to family and children had lessened they had more opportunity and time to enjoy themselves:

one glass of red wine a day with a meal, sometimes a couple, never excess and you know, and occasionally none. And that, for me, feels very comfortable, I don't feel like a drinker, I just feel at last, having got rid of the family, I'm…actually allowed, yeah exactly, I can actually afford to treat myself and have a couple of glasses of wine.
(Sonia – women's focus group)

Although this might indicate an increase in women's' drinking as they enter later life it was also pointed out that much of the keeping fit and healthy 'anti-ageing' industry was aimed at women and many may respond to this by drinking less. As Louise explained in relation to her friends:

I mean there's a lot of, we're all living longer and we're all getting fitter as we get older, and there's so many women now taking health things … all these health magazines and going to gyms and looking after their health.
(Louise - women's focus group)

Highlighting the fact at different stages of the life course women are likely to have different priorities and this may relate to their drinking patterns, Winnie commented that:

You sort of hit fifty and you have more because you can because your kids have left. Then by sixty you start the tablets ... so you have to cut down.
(Winnie – women's focus group)

As we will see later in more detail, participants from the interviews expressed a range of views and perceptions of their own drinking practices. For many, having a drink was considered a normal part of everyday life, and although habits may have changed over time, it was an unremarkable constant feature. Tom, who had always enjoyed going to the pub on a regular basis throughout his life explained:

I mean to be honest with you, I think when you go in a public house and you see older people around my age, they're just the same as I am, just come in and enjoy a drink and that's it.
(Tom - interview)

In relation to getting older and particular aspects of ageing, many recognised that alcohol may be used as a way of coping. Although some firmly believed that 'drowning your sorrows' was not a solution, there was sympathy and understanding towards older people who may use alcohol in this way if they are lonely or isolated. Maggie from the women's focus group felt it could be a problem for older women who were widows:

A few women who I know, who are widows, slightly older than me, and don't go out much, and to keep on a brave front they pretend they don't drink, and I've happened to call on them and found them under the worse, so I think that is very sad because they're at home, lonely, drinking to forget their loneliness.
(Maggie – women's focus group)

Drinking practices and styles

Even within our relatively small sample, it became clear in relation to questions around 'why', 'where', 'when' and 'who with', that people engaged in different drinking practices. In order to understand the meaning of alcohol in their lives we divided different drinking practices into 'different styles' (table 8). It is important to note, however, the variation within each style (in typical amounts consumed, the 'who with' and 'where') and that the boundaries between different styles are not fixed. It is equally important to note that as researchers we are grouping different drinking practices into four styles and this has involved a process of interpretation and selection and risks oversimplifying the multiple meanings that alcohol may have. For example, one participant who drank alone everyday (up to 2 litres of whisky per week) and whose drinking practices, would fit style 3, described enjoying alcohol and might well choose to classify himself as a social drinker.

Why	How often	Where	When	Who with
Style 1 Social - regular	Every day	At home	Evening meal	Partner/spouse
Style 2 Social - occasional	Variable	Out / friends / home	Part of meal/ evening out/ social gatherings	Friends / spouse
Style 3 Heavy lone drinking	Daily / weekly	At home / pub / street	All day/ during the day/ evenings	On own
Style 4 Heavy drinking in a drinking network	Daily / weekly	At home / pub / street	All day/ during the day/ evenings	With friends /other drinkers

Table 8 Drinking styles[2]

Drinking style 1: Social – Regular

Typically within this style alcohol was seen as something enjoyable and pleasurable. It was connected to positive social interaction and drinking was characterised by an experience shared with spouses or friends. It was, in the main, something that took place at home as part of the evening meal and a daily activity. Jane's account was typical of this style as she described sharing a glass of wine with her husband in the evening:

> *It's probably beneficial… it's part of my relaxation after work and generally enjoyment. I tend to drink red wine … and I think it's quite good for me all-round … definitely part of my relaxing and being at home process … quality of life.*
> (Jane - interview)

[2] The government categorises types of drinking into: 'sensible', 'harmful' and 'binge' in the National Alcohol Strategy. Whilst the government defined styles overlap with the styles we identified they do not fully capture the drinking practices of the older people in this study.

Several of the women who described this style of drinking said they probably would not continue to do this if they were on their own or if their husband was away, as Angela explained it was very much a shared experience:

> *I wouldn't open a bottle for myself because it's a social thing. You have a glass of wine and you're talking... with my husband or when you're cooking.*
> (Angela - interview)

Drinking style 2: Social – Occasional

The second style was similar to the first in that drinking was linked to social occasions and, in particular, to food or meals out but less frequently than every day. Participants who described this style of drinking included those for whom alcohol had always had little significance in their life as well those who described becoming occasional social drinkers as a result of changes. These included health related changes for example, cutting down on the amount of alcohol because of health conditions and taking medication. For others drinking had been reduced as a result of living on their own, and of the eight participants who described this style of drinking five now lived alone as a result of divorce or widowhood. Sue explained how she had drunk more regularly before her husband died as it was something they did together:

> *There's something about it that feels like a return to a happier time in my life, do you know what I mean? … when my husband was alive and it was something we could enjoy together, just sitting, having a meal and a glass of wine. And just having one always takes me back and I would think that that's probably quite important for a lot of people. It evokes a lot of memories of happier times.*
> (Sue - interview)

Drinking style 3: Heavy lone drinking

The defining features of the third style, as the name suggests, were regular drinking in larger amounts, alone and outside of social interaction with others, usually at home. There were several participants who adopted this drinking style for different reasons. For one who liked to drink whisky, cost was a primary factor as he couldn't afford to drink whisky in pubs; for another who had limited mobility it was difficult to leave the home and visit the pub. Within this style it was more difficult to identify a 'typical' participant as the individual biographies varied and linked both to habits over a lifetime and transitions into older age. Although not 'typical' of the other participants, Katie's story illustrated this style. She lives with her husband and adult son but likes to drink a bottle of wine in the evenings on her own as she explained:

> *I do not enjoy going out and meeting people, sitting in pubs and shouting at the top of my voice. When I come home, this is my haven, I want to be here. I feel it… I don't even like drinking with, say if I had my friend come*

over, and she's very moderate, she drinks like a little… you know. So I feel embarrassed then. So I'd rather drink on my own.
(Katie – interview)

Drinking style 4: Heavy drinking in a drinking network

The last style is also at the heavier end of the drinking spectrum but in contrast to being a solitary activity, it includes elements of social interaction and takes place in the company of other drinkers. The networks included those who were social contacts because they drink as well as friends who drink together. Participants who had this style of drinking included those who had drunk heavily over a long period of their life and had started drinking in their early teens. In terms of location, this style of drinking was typically outside the home. All of the participants whose drinking fell within this category were male and for many pubs and friendships connected to the pub had played a large part in their lives. But for others, this style was connected to street drinking and two of the participants talked about the people they drank with in terms of comradeship and looking out for one and other. Andy who lived in a hostel described his relationship with another resident:

he's a right pisshead too, so he's my drinking buddy, know what I mean, and if I've got money I buy the booze, if he's got it he buys it, see I get paid fortnightly but he gets paid weekly so I carry him sometimes and then when I've no got it he carries me you know, tit for tat.
(Andy – interview)

Key themes which emerge across different drinking styles

In addition to the different styles, we identified a number of themes that related to drinking practices and decisions around alcohol consumption. These themes cut across the four styles but appeared in different dimensions within each style. This highlights the complexity of the relationship between individual biographies and external factors and circumstances. In line with the approach we have taken, we detail these themes to understand drinking practices within the wider context of people's lives and personal histories over the life course.

Social relationships

The ways in which social relationships connect to drinking practices were wide-ranging and varied according to individual circumstances and within different drinking styles. For those who were regular or occasional social drinkers, alcohol was a part of their social life and socialising. For many of the participants, having a drink had positive associations with enjoyment, relaxation and leisure. As already outlined above, drinking within the first two

styles is closely connected to social contact and connected the participants to others: spouses, partners, friends, places or groups of people, both in the present and in the past through 'happy memories'.

It was clear that alcohol was an accepted and normal part of socialising, but for some who were very occasional drinkers this could operate as a barrier to their social lives. Linda, who drank very little but liked to have an active social life, explained how a lot of the activities that she enjoyed took place in pubs and that this could be difficult if you weren't really a drinker:

> *Yeah, when I meet friends in pubs they seem to, it's like smokers who like to be with smokers, it's a comradeship you know or camaraderie or whatever and the drinking is the same thing so it's almost like you've got to move out of that social group because you can't keep up with them*.
> (Linda – interview)

In Linda's case she found ways of negotiating a social life without drinking but she felt this was not always easy given the dominance of drinking within British culture:

> *I made a friend there, a girl friend and she believed in sort of, I realised she needed a drinker with her because she was a drinker, what I would call a drinker, so we fell out very quickly because she would have, she's a gin drinker, she drinks in the morning and I of course didn't know any of this, and of course I would be there with my half which would last me, I wouldn't need anymore, and of course every time she got her round I'd have to get her a round so it was too expensive for me having to buy her drinks and they're about £3.50, £4.00 now, so she lost her temper with me one day and I said, "No, it's not going to work out me going out with you" because I said "I can't afford it anyway".*
> (Linda – interview)

As described above, for those participants who fitted within the fourth style the extent and nature of their social relationships were closely connected to their drinking practices. The participants who had experienced street drinking in particular, only spoke about their relationships with other heavy drinkers and one was estranged from his family. These relationships were important in that they offered not only sociability and a sense of belonging but also a degree of support and protection. There were however, disadvantages to belonging to a network of drinkers or only having friendships with other drinkers. Ian, who was a long term heavy drinker but had cut down his drinking and got it to a controllable level following a detox, described how he didn't really talk about that with his drinking friends:

> *I'm trying to keep it quiet, I'm not even since the detox, I've only told certain people that I've come off the alcohol and the others, you know, I could still actually fool them, I could stand there with a coke and they'd think there's vodka in it and I think more fool you. But then again, it can work both ways like they always think I'm not given up, but some things you think, well, you know, just keep them to myself and that. When I go*

out to the pub and that, you know, some people might say oh not drinking tonight, and I just say oh I don't fancy one or I'm bloated or you know, I'm having one in a minute.
(Ian – interview)

Loss

We asked about changes in drinking habits at different times in the participant's lives and explored life changes and transitions. These included changes in relationships, work, health, housing and moving to a different area. Many of the participants described events and emotions which, to varying degrees, had impacted on their drinking practices. Some of these could be described in a general way under the theme of 'loss'. This was expressed in terms of loss of partners, family and friends through bereavement as well as loss of physical health and mobility, daily routines and structures.

Participants talked about how they had adjusted and coped with these changes. In relation to bereavement, it was acknowledged that this was a particularly difficult time and one in which alcohol may be used as a way of coping. Sue, who lost her husband four years ago, commented:

It's a very difficult situation … to be left on your own after 'x' number of years. And I think people have to find their own ways of dealing with it. … I can understand … it's like … this low point of living on your own and losing somebody and feeling like you need something to boost you over these really low points and I can understand that if in the past you've turned to alcohol to change your mood you would be quite tempted to do that.
(Sue – interview)

Like Sue, when Lily was widowed she found she drank less than when her husband was alive. In the immediate period after he died she recalled that she was actively encouraged to have a drink by a family member to help cope. Although she had not found this helped her she did describe how she would occasionally have a glass of wine as a 'pick-me-up':

If I am here on my own and I've been out and I'm cold, or something's triggered me off over my husband that's made me a little sad, I will get out a bottle.
(Lily - interview)

Those participants who had not yet directly experienced this type of loss were also aware that losing your life partner might act as a trigger to change a person's relationship to alcohol. Angela, whose current patterns fitted into the first drinking style, and regularly enjoyed sharing wine with her husband reflected on this:

I know that if you have a bereavement you would tend to … what they say 'drown your sorrows' but I don't think I'd do that, of course you don't know until it happens. I'd like to think if I were bereaved I wouldn't take to the bottle but people do don't they?
(Angela - interview)

Some of those who had drunk heavily over a long period of their lives also mentioned loss of loved ones in connection to alcohol and increases in their pattern of drinking. Andy, who had been a street drinker, traced the start of his heavy drinking to when his first wife died leaving him with three young children:

So I mean everything just from then went down, me hitting the drink that much, my mother-in-law blamed me for her death.
(Andy – interview)

Much later in his life he had managed to stop drinking but started again after his brother was killed in an accident:

See I was dry for 18 months, that was up to the point where Frank was killed, right so I was at the wake and somebody put a glass of whisky in my hand and I drank it before I knew what I was doing … and I just went "give me that bottle" and I just sat there and drank the lot.
(Andy – interview)

Current and previous lifestyle

Other types of loss connect to change and the relationship between current and previous lifestyle. For some participants declining physical mobility had impacted on their drinking patterns and where drinking takes place. For many of the men going to the pub had been a regular activity throughout their life and one which had carried on after retirement. Tom, a retired bricklayer, would usually go for a pint after work and the pub was an important place of social contact. Following a fall he had difficulty walking and getting to the pub on his own:

I'm not an alcoholic, I just like a drink and I used to have a few drinks was out a couple of hours and then come home. Never see us out all day or anything like that… never had a drink in the house, I used to go out.
(Tom - interview)

As a result he had taken to having his daily couple of beers at home on his own, although at the time of the interview he was waiting for an assessment for a mobility scooter which he hoped would give him back some independence in terms of getting out.

Tom's account illustrates the connections to drinking practices over the life course, and the desire to maintain activities that had always been a part of

one's life, but from which people may become excluded as they grow older. How participants had responded to changes very much varied according to individual biographies and circumstances. For some the transition into retirement marked an increase in drinking but in different ways. Both Toby and Larry were divorced men living on their own and who described how their drinking had increased on retirement. For Toby, this had entailed going to the pub more often but Larry drank mainly at home:

> *Once I retired I found myself going into pubs practically every day, although I used to do a lot of walking, I'd pop into a couple of pubs on the way… there was hardly a day when I didn't go in a pub for at least two to three pints something like that … because mostly I drank on my own, although I went into pubs where I know people, you know, so I can talk to them and so on, you know socialise and everything.*
> (Toby - interview)

> *Of course when I was a taxi driver, I didn't drink so much because I couldn't, you know being a driver …so really I suppose it's six years ago I retired I suppose that's when I started drinking more.*
> (Larry - interview)

For others, retirement signified a period where their time was now their own to enjoy and marked a change from the daily responsibilities of work and family. Both Angela and Christine who were regular social drinkers reflected on when they were younger and did not have the time or money to enjoy social drinking everyday:

> *I do possibly drink more now than I did before because I'm in more … as I've got older and staying in. I've always had wine if we've been out for dinner but it's really only in the last … 10 to 15 years that we've had a bottle of wine a day because we can afford it.*
> (Angela - interview)

> *It* (the amount) *probably has increased because we can afford it more now. When we just moved here we had a huge mortgage and two young children we could not afford to have a bottle every day. If you have a young family you can't afford to go to the pub.*
> (Christine - interview)

Financial impacts

When we asked the participants questions around any financial impacts that alcohol had on their lives a lot of issues about the cost and availability were raised. These connected in different ways to the drinking styles. Most of those who were regular social drinkers spoke about the affordability of wine and that this was one reason why they could drink wine every day with their meal. Many described buying wine on special offer from supermarkets as part of their weekly shopping, as Henry and Angela explained:

Now when I go to the supermarket I get wine … its always on offer £7.99 reduced to £3.99 and you can afford that.
(Angela – interview)

Usually we buy our wine at Sainsburys because they do have lots of good offers. We go there to do our shopping every week, and if they've got anything that's good and it has 20% off I'll buy a dozen bottles.
(Henry – interview)

Cost was also mentioned by those who were more occasional social drinkers, some of whom spoke about how they couldn't afford to drink more than occasionally. Linda, who was on a low income and carefully budgeted for her social activities, found that on some occasions when she was in pubs the alcohol was cheaper than the soft drinks:

It's just social drinking, yeah and if I could get away with without buying it I would and that's just because on a pension you haven't got a lot of money. Yeah a pint for £2.15 which is very cheap which is about £1.50 off £1.25 off, now that lasts me the whole evening, a half pint would be sufficient but the trouble is the room gets hot, the reason that I have that, is that the lemonade is dearer which doesn't make sense you know they charge a lot for the soft drinks and you know if it was a soft drink and it was cheaper you'd buy one.
(Linda - interview)

For the heavier drinkers, the cost of alcohol had a more direct connection to drinking practices. One of the participants whose patterns fitted the third style of drinking heavily alone explained that he would not be able to afford to drink the same amount of whisky if he went to the pub. On occasions when he went to the pub he chose to drink lager as this worked out cheaper. Andy who had been a street drinker and was unemployed described how the amount that he drank completely depended on the amount of money he had to spend. Ian, who had been a heavy drinker for most of his adult life, linked an increase in his drinking to the time that supermarkets started selling cheaper alcohol:

that was a kind of turning point in a way because the pubs seemed expensive and I think you could trace it back to the mid eighties where there's supermarkets and that were selling cheaper booze you know, but made me buy the 3 litre bottles rather than the pint bottle now and that. You can go in the pubs and that and pay nearly £3 a pint, whereas you can go into an Asda's and buy it by the can load and it works out about 60p a pint.
(Ian – interview)

Ian explained that now he was controlling his drinking following detox he found it easier to avoid buying alcohol in the supermarket than in new convenience shops that are open late:

go to any Happy Shop or convenience store … it's there right in front of you and it's far easier to, I find, to go round the supermarket and not buy

alcohol than it is to go to a convenient store. Yeah, because the convenience store, it's very cheap, and sometimes you're waiting at the checkout, you know, the till, the one till and you think, oh I'll just grab four cans just like I can carry them home…And that's the thing because you do need the convenience stores now and then, like everyone will, if I'm out of bread and milk, you know, get some cat food and you just walk up there and before you know it you've bought three bottles of wine for a tenner or something, you know.
(Ian - interview)

Health, well-being and growing older

As well as the financial impacts of drinking we asked if alcohol had had any impact on health. A number of participants talked about changes in their lifestyle as a result of health issues and the ways in which these related to drinking practices. Many of those who were taking medication had reduced the amount of alcohol they consumed. People had adjusted to this change with varying degrees of ease or difficulty according to the place that alcohol had in their lives. For Ben, who had always been an occasional drinker, cutting out alcohol following a heart attack was not a problem. In contrast, those for whom alcohol had played a bigger part in their social activities, adjusting to their current situation was more difficult. Mark described the strategies he used:

I was a good drinker before I had my stroke but now if I go out to have a drink I have half a lager and half of tap water, I have it mixed with the lager and I have two pints, right so that's four of them and that's my lot.
(Mark - interview)

Bill, who had been a heavy drinker, most of his life and had a number of health problems, including diabetes, adjusted his medication so that he could drink as he explained:

You're not supposed to take certain pills when you're having alcohol so you work it … so 8 hours … you think am I going to have a drink today because I know so and so is coming round to see me so don't take those pills. You're alright for about 72 hours then after that you've really got to settle down again.
(Bill – pilot interview)

For others, worries over their health had been a motivating factor in making changes in drinking patterns. Ian, who like Bill, had started drinking in his teens and had drunk heavily most of his adult life decided to go for detox after a friend who also drank heavily was rushed into hospital:

I kind of knew that drink was bad for you in vast amounts but it was oh well if it does, it does. But when I saw that she was fitting and all this lot

and I'm thinking, yeah that could be me in a few years time I could be diabetic, going diabetic with it.
(Ian – interview)

Most of the participants whose drinking practices fitted within the first two styles of drinking (social – regular and social – occasional) did not feel that alcohol had negatively affected their health and many referred to a daily glass of red wine being recommended by doctors as good for the heart.

Responsibility, control and independence

From a broader perspective of understanding well-being, the themes of responsibility, and maintaining control and independence emerged as important factors. Like the other cross-cutting themes, there was considerable variation over what these meant on an individual basis and how alcohol did or did not play a part.

There were various ways in which participants appeared to make decisions around controlling the amount of alcohol they consumed and many had their own self-imposed 'rules'. These included having only one drink a day, not drinking every day, not drinking before a certain time in the day or not drinking at home. Linda, who only drank when she was out doing her social activities, explained why it was important to her that she bought her own drinks:

I will buy my own drink and I'm in control … and it's very hard … if they offer you a drink and you're trying to be polite… but I just say 'it's not that I'm mean but I can't afford it anyway and I like to know what I'm drinking … and that's' the best thing I ever did because when I sort my money out I know exactly where I am and I keep more in control that way and I feel happier for it.
(Linda – interview)

Being in control and maintaining a sense of independence were also linked to decisions about how to spend time and what interests and activities to pursue in the face of growing older. Sue who was in her eighties spoke about how for her it was important to make the most of her time, especially while she had the health and fitness to be active. She felt that having some structure to her time and routines helped her to cope with aspects of getting older:

Well I think you see it's very easy to feel you're a waste of space and to be …and you know to think "oh it's all too much effort and do I want to go on"…and I think friends and just encouragement to go out and do things and not … it's somehow finding the motivation to go out and do things. … I've always enjoyed other people and my whole working life has been with other people and relating to strangers and I'm interested in other people. And I don't know, it's perhaps the loss of interest in other people that makes you turn to maybe things like alcohol.
(Sue - interview)

As we outlined earlier, there were connections between alcohol use and social life and these had varied considerably on an individual basis. Highlighting the different ways that people respond to their circumstances, two of the participants found themselves in very similar situations but responded differently. Both men were living alone in sheltered housing and going to pubs had been an important part of their lives. Toby found when he first retired his drinking had increased and he had been going to pubs more and more, partly for social contact. As he describes here his habits changed significantly when he moved into sheltered housing and got involved in the organised activities on offer:

> *Because here you see people everyday and get to know people. And you don't feel the need to have a drink anyway, you know, not like I used to do*.
> (Toby – interview)

In contrast, Tom chose not to join in the organised activities in the scheme where he lived and relied on his children to take him out for social activities.

For Linda it was important to find ways of keeping busy and enjoying herself that did not involve drinking and this was also connected to the issue of responsibility and part of taking care of herself:

> *I think as you get older your life … you're responsible for you own health first and foremost and you can't go around blaming anyone if you're overeating, over-drinking … but like we're all human so we're all tempted at times.*
> (Linda – interview)

However, Linda also raised the issue of the collective responsibility of the government, the drinks industry and supermarkets to tackle alcohol problems and had found she occasionally drank more than she planned to because of special offers and cheap drinks:

> *Yeah it was personal responsibility for me but on the other hand the publican is tempting people to drink that bit more whereas a single would have done for me and I might not have had that, you see it was a double.*
> (Linda – interview)

Seeking help

We asked participants if they had ever sought help with alcohol issues and where they would go if they felt they needed help. The participants whose drinking practices fitted the social regular and social occasional styles had not sought help and did not think their drinking patterns required any help. Generally in response to the question on where they would seek help most thought that their GP would be the first place they would go.

There was more ambivalence among the participants whose drinking patterns fitted the two heavier drinking styles. This ranged from not perceiving their drinking as a problem at all to an acknowledgement that they were aware they were drinking above the recommended safe levels but reluctant to make any changes.

Larry, who went for regular checkups and said his GP was aware of what he was drinking, felt that he might only reduce the amount he drank if his GP strongly advised it. He enjoyed drinking and regarded it as one of his remaining pleasures and that is life would be less enjoyable without it:

> *Well I'd probably enjoy life less if I didn't have a drink … and I think to myself I had a couple of mates a similar age and they packed up drinking and smoking and they was always ill and depressed and moaning, I don't want to get like that.*
> (Larry – interview)

Katie was very aware that her levels of drinking were above the recommended limits but felt that this was her way of dealing with the stresses in her life and worried that if she was advised to stop drinking altogether she would not be able to cope:

> *That might be the only place I feel happy, is from the drink, in a really rotten world, and lonely world. And you take that away.*
> (Katie - interview)

Some of those in the heavier end of the drinking spectrum had made changes as a result of GP's advice. When Toby had had a problem with his blood pressure he responded to the doctor's advice and reduced his drinking without any further help:

> *My doctor told me that if I didn't cut down on my drink and get my blood pressure down, I could have a stroke or a heart attack… she asked me how much a week do you drink, and I said something in the region of 21 pints and she said that's much too much and she pointed out the different units and that sort of thing and she said you must cut back on it and so I did.*
> (Toby - interview)

When Ian decided that he wanted to do something about his drinking he asked his GP to refer him for detox. When he reflected on this he was surprised that the GP hadn't suggested this to him before:

> *I don't know if my GP could have done more about it, I mean when I used to go up there, they must have had a record that I drank heavy but they kind of just accepted it, he's a heavy drinker and that's it, you know, like I said I was 50, 49 before I got this detox, you know, and it was never really suggested you know, ten years ago or something like that.*

And I have been on a lot of medication so I was drinking on medication which probably doesn't work, here even depressants.
(Ian - interview)

Before Ian had his detox he had tried going to AA meetings but had found listening to long time members who had been dry for many years was off-putting because he worried that he would not be able be stop drinking even for a few days. During and after the detox he had received one-to-one counselling and support which he had found helpful. This was coming to an end at the time of the interview and although he was determined to keep his drinking under control and down to recommended safe levels it was still early days into a new way of life and he was not sure what ongoing support he would be able to access.

Andy, who was another long term heavy drinker had had two unsuccessful attempts at detox and had also not found AA helpful. He found talking openly about his drinking and his behaviour within a group setting very difficult:

I've been twice to an AA meeting … and they're all getting up they speak on a podium, and they're all boasting about the things they've done. I'm ashamed. I mean I'm totally ashamed (of the things he's done while under the influence) *I could never tell anyone.*
(Andy – interview)

What the above accounts illustrate is that the question of seeking help is complex and that support needs can vary on an individual basis.

Differences

We have highlighted the differences within individual life histories in relation to the cross-cutting themes that emerged within the interviews. Although we were not able to fully explore differences in experience that may connect to structural factors, such as gender, ethnicity, sexuality in great depth we reflect on these issues in the following section.

Cultural differences

In some of the focus groups there was discussion around the ways in which drinking appears to be deeply embedded in British culture. Two participants in different groups were former publicans and they reflected on the role pubs had within working men's lives and how pubs have changed in the last twenty years. Participants in the BME focus group described cultural differences in attitudes towards alcohol and how this was something they had noticed on coming to live in Britain:

When I first came to this country in 1962, there were so many pubs everywhere, pubs, pubs, pubs, more than shops, if you see what I mean.

And that's the social place that people meet, in the pub and there's always drinks. So from an early age, the youngsters know that is where you go to have a drink and meet with your friends and what have you. So you know, it's inbred in children growing up in this country, that that is the social outlet, if you see what I mean.
(Edna – BME focus group)

But then you get a sort of cultural thing here, because when I came from the West Indies in 1960, I was surprised to see that meeting in the pub was one of the events where people socialise. Now in my country, we didn't have pubs as such. I think that you know, people from a different culture, they may not find that alcohol is a problem as such because if they had grown up in a culture where drinking isn't something which people go for, regularly, I think they bring their attitudes with them to the host country. I think it's cultural you know, if you come from a culture where you don't habitually drink, it's not too big a problem, I would say.
(Clive – BME focus group)

Some of the group disagreed with this point and felt there were alcohol issues within minority communities but these were less visible and more stigmatised. Reena and Samira described the situations of people they knew from their communities:

I know that from our culture, is not allowed to drink, women and their mens as well but I notice some of them, they came to this country because open and they can drink at any time. I know some broking the family, some of them because they are drink a lot.
(Reena – BME focus group)

Yeah, sometimes people from a different culture where the drinking is restricted and particularly where the women are not allowed to drink publicly in their country. They come to Britain and there's more liberty, you know. They're free-er to do the things that they couldn't do back home. And you find they fall, they get into bad habits just as how the host population does.
(Samira – BME focus group)

Although these discussions provided a comparative perspective for the study and raised interesting questions on cultural differences we were not able to fully explore the role of alcohol in the lives of older people from minority ethnic communities in more detail. The focus group discussions suggested that increased stigma around alcohol use and the possible 'hidden' problem needs to be better understood.

Gender

Reflecting on the accounts of our participants we were aware that the ways in which men and women described the role of alcohol in their lives and their attitudes towards drinking connected to wider issues of gender differences.

Other studies have shown that men and women's different patterns of drinking reflect gender roles and norms of behaviour (Waterson 2000). Historically different moral attitudes and values were associated to women's roles as mothers and carers within the private world of the home and family, whilst men were more closely connected to public spaces, such as the pub and the workplace. Some of these themes, although not explored in great depth came through in our study. Two participants from the focus groups who were former publicans reflected on the different relationships that men and women have to pubs:

> *A pub always used to be a centre of influence, you had a mechanic, a plumber, a decorator and you could go in there in a certain period of time and if you mentioned that you needed something doing at home you know, somebody will pop up and say "I'll do it".*
> (Eddie – BME focus group)

> *I know they had special bars for women years ago … they had women in the bar and it was only women in there and sometimes they had men's bars.*
> (Betty – day centre focus group)

As we have already described, for some of the male participants going to the pub had been a long standing part of their lives and one which they continued, or would have liked to have continued into their later years. In contrast, women's social networks were not so allied to the pub unless it was with their husbands and this has been reflected in other studies which highlight the implications of gendered social networks in later life, particularly for older men (Davidson 2004, Jeffries 2008).

There was recognition among some of the female participants that they were of a generation where drinking or going to the pub was not something that women did. Sue, for example, reflected on how things have changed in relation to the way her daughters drink:

> *You know in those days wine wasn't drunk as much as it is now, nearly everybody has it. It's a cultural change and if you had people for a meal you would buy a bottle of wine but it wasn't the way it is now … and the way my daughters … they would probably sit and have a bottle of wine in the evening and that would be different.*
> (Sue – interview)

The relationship between women's family roles and alcohol also emerged in different ways. One of the participants who had spent most of her adult life caring for her disabled son and her mother described using alcohol as a way of coping with the stress of her life and as a way of creating a separate space for herself. She described the tension she felt between looking after others and wanting time for herself:

> *And maybe I have to… I mean, there's part of me I know I have to be living as long as I can because of my son, but then I always feel I'll*

always be looking after people. And I think well stuff it. And then of course you have this seesaw effect, so one minute you think oh stuff the lot, and the next minute you feel really guilty.
(Katie – interview)

In contrast, some of the participants in the women's focus group described having less responsibility in relation to their families and caring, and this created the opportunity to enjoy drinking as a social activity which was not available to them in the same way when they were younger.

Sexuality

As previously described, our intention was to try and reflect Brighton and Hove's diverse population and this included capturing the experiences of LGBT older people. We were not successful in recruiting participants for either focus groups or interviews and were keen to reflect on the reasons for this. We include some thoughts on this here as they illustrate the difficulties of researching the lives of people who have experienced marginalisation and shed some light on how this also connects to issues related to alcohol use for older gay men

In discussing this with a representative of an older gay men's group we learned that members of the group were not prepared to talk about their private lives with someone they did not know and with whom they had no relationship of trust. It was clear that for the generation of older gay men who had lived all their lives keeping their sexuality hidden as well as living through the period when homosexuality was criminalised and punished, discussing their private lives with a stranger would be very difficult. Questions about drinking habits may raise painful issues related to isolation, being rejected by family and discrimination experienced over a long time. The impact of a lifetime of facing this discrimination and the deeply engrained sense of having to hide one's sexuality does have particular impacts in later life.

In relation to isolation this goes beyond issues related to retirement and bereavement which may affect all older people to varying degrees, because in addition to these factors older gay men may also be isolated from family and have little in the way of family support. For those gay men who find it very hard to talk openly about their lives, it is much more difficult to access services, ask for help and seek support. Housing, care and health needs for this group are therefore, likely to be unmet or overlooked. This is particularly an issue where gay men do not have their relationships acknowledged or through a lifetime of having to appear 'straight'.

Although Brighton and Hove is known for having a vibrant gay community there is a lack of social spaces and activities that cater for older gay men. Apart from one notable exception - a gay-owned hotel which once a month hosts a senior citizens event – the lack of social spaces is likely to impact on drinking practices and in particular, drinking in isolation at home.

These reflections suggest that issues in relation to the needs of older people which are overlooked within the general population are likely to be worse for people who are already marginalised and 'hidden' because of their sexuality. Although it should be noted that we were unable to explore these issues with older lesbians through either focus groups or interviews so cannot comment on possible differences or commonalities in the experiences of older gay women. However, through reflecting on the research with an older woman who was a member of a number of lesbian social groups we were made aware that gender differences in social networking referred to earlier, may also be reflected within LGBT communities. The activities of older lesbians' social groups described by this woman indicate that social spaces and kinds of activities focus less on pubs and drinking and that a strong sense of caring and looking out for each other provided support which lessened social isolation.

Brighton and Hove as a drinking place

Other studies have highlighted the significance of 'place' – the local culture, geography, and economy – in relation to drinking practices (Thomas and Bromley 2000, Valentine et al. 2007). Although these were not issues that were in the forefront of this study they did emerge in some participants' accounts. There was a perception that certain places were unsafe for older people because of the dominant drinking culture. Some of the participants commented that they would not go into town at night because they feared young people's behaviour. Although this is an indirect affect of other people's alcohol use it might increase isolation and the likelihood of drinking at home.

The view that areas of the city, and particularly leisure and social spaces, are aimed at younger people can add to a feeling of exclusion for older people and exacerbate their fears around not feeling safe. This in itself leads to further fragmentation and division within the whole community and increases the lack of understanding between generations.

Many of the older people in this study talked about the pub in both the past and present as a place of social contact as well as somewhere they would drink. Within the focus groups there was some discussion of how pubs have changed over recent years. Bob for example, remembered the pubs he went to as a young man as places that brought people together:

> *the pubs I used to go to in London, it was really entertainment going there, I mean you know you'd have the old piano and everybody was singing …no it was a nice thing, you know like all the old songs with the old piano and everybody joined in.*
> (Bob – day centre focus group)

There was also discussion on how local pubs have become 'up-market' and cater for different sorts of customers. Former publican Eddie described these changes and how he thought that impacted on people's drinking habits:

> *Pubs have changed their images, they're going more into food and they've stopped the smoking and also the drinks are expensive there, so that's reducing the certain type of people because they can't afford it. If you're looking at say three pints of beer and it's a £10 note which it is today, you're not going to drink as much because you're drinking by your pocket. And on the other hand, you've got supermarkets and you've got off-licences who purvey an awful lot of drink at an extremely low price. Very high alcohol content and that can be distributed widely and that will lead to drinking at home.*
> (Eddie – BME focus group)

Participants also raised the issue of the change in the licensing laws that have increased the availability of alcohol in terms of longer pub opening hours and late night shops. Ian, who had been drinking since his teens, described the changes over the last few years. At one time he would leave the pub at eleven o'clock to catch the last bus home at ten past eleven. Since the extension of pub hours there was now a bus running through the night and all night convenience shops which sell cheap alcohol offering more opportunity to drink. Ian felt this was a problem, for himself as a heavy drinker trying to control his drinking, there was more temptation and it was more difficult to avoid, but also for younger people who had not yet learned their limits:

> *Yeah, it's an epidemic down town, yeah, it really is. And I don't know how in general they're going to crack the problem of you know, binge drinking when it's you know, it's everywhere. You could almost say 24 hours a day, you know….It's so much easier and the problem is getting worse by the year like I said, you know, a couple of years ago supermarkets didn't have a license to sell after 11.00, alcohol, whereas now they do, so you know.*
> (Ian – interview)

These issues relating to the nature of Brighton and Hove and the city's attitude towards alcohol and how this might impact on older people's drinking practices have not been fully developed within this study. However, the discussions in the focus groups and interviews suggests that recent developments within the city in relation to the night-time economy have created particular issues for older people and those with problematic drinking patterns and that this is area that needs to be understood further.

4. Discussion

In this section we discuss the findings of the study in relation to a number of perspectives that reflect the different professional backgrounds and interests of the partners that have been involved in this project.

Rather than making clear recommendations we start by offering the reflections of the community supervisor, the university supervisor and the research officer on the findings and by drawing on other work that is relevant to understanding older people's lives. We then go on to look at the findings in relation to policy and service issues for health and social care, housing and drug and alcohol services.

This was a small scale qualitative study conducted in selected areas of Brighton and Hove. We do not claim we have a representative picture of older people's use of alcohol, but this study does offer insights into how a selection of older people view their drinking and what it means to them. In view of the limited research on this topic this study makes a useful contribution to understanding. Although we cannot know how typical the older people we spoke to were, the focus group discussions did enable us to get a wider perspective by asking participants to reflect on the relationship between ageing and alcohol use more generally.

Older people drink in different ways for different reasons. For some it is associated with pleasurable social interaction or time for themselves. In other cases drink fills an absence in their lives and may have become an activity they cannot live without. Having an active engagement in activities involving others or having a role seems to play an important mediating role for those who might be tempted to drink too much. Drinking companions may be a source of both friendship and problems. Within our sample any harm that was caused was to participants themselves rather than others in most cases. Those who drink heavily were rarely in situations where they are caring for others and their drinking did not spill out into public behaviours that cause difficulty or offence to others. Amongst those we spoke to there was often an awareness of their drinking and a wish to maintain control of it – even in situations where others might suggest they were being reckless with their health. Many of the participants were both critical of and negatively impacted by public drunkenness of younger people.

Older people's drinking is affected both by their personal circumstances and biographies and by social and economic circumstances. The greater availability of alcohol and its comparative cheapness plays an important role in this. There appear to be differences amongst older women and men in their drinking patterns and we have some limited indication of the likely impact of ethnicity in attitudes towards alcohol and drinking amongst this age group. Given the limitations we have outlined and reflecting on the 'silences' in our study, we would suggest that a fuller understanding of the significance of differences would need to explore the impact of multiple forms of

disadvantage and structural inequalities on older people's alcohol use, in relation to the impact of racism, sexism, hetrosexism as well as ageism.

We deliberately did not seek to identify older people who were already receiving specialist help because of their use of alcohol and few of those we interviewed felt they needed to seek help. Whilst the GP was usually identified as a likely port of call if people did feel the need for help, our findings do not suggest that it would be useful to define older people's over use of alcohol as primarily a health problem. Some of those we interviewed lived in sheltered housing, and were receiving other social care services but these were not suggested as sources of help if older people did feel the need for this.

What does this suggest for the development of local strategies or services?

Maintaining social spaces where older people can meet others and enjoy a drink together is likely to be important for many older people. Pubs that serve good food at reasonable prices can offer a focus for social contact and 'safe' drinking. Where mobility and physical access issues impede older people from using pubs and other social spaces this may lead to lone home drinking which can become heavy. The issue of the changing nature of pubs were raised by many and the extent to which they do not appear to be geared towards attracting the custom of older people. The gay-owned hotel that had initiated a senior citizens event had done so after a change in ownership and a new, older manager. Publicans could play an important role in providing facilities for older people. This is an issue that is relevant in the context of urban planning and local regeneration that go beyond the scope of this project and has implications for the development of tourism and marketing the city in ways which may exclude older people.

The capacity to continue to take part in a range of social activities that engage older people's interests and skills, and make them feel that life is still worth living is likely to limit the likelihood that alcohol will be used to mask loneliness. In some cases people may need to be actively encouraged to take part as they may be unused to mixing, having been used to being one of a couple in social situations for much of their lives. Low key facilitation and befriending schemes may be important here. The value of collective activity should be promoted – whether that is yoga classes, engagement in campaigning, or taking part in activities at a day centre. Sheltered housing and other residential facilities for older people are a potential source of social contact, but residents may still wish to maintain contact outside – including going to the local pub. Sheltered housing staff are well placed to play a key role in facilitating older people's engagement in activities that may act in preventative ways to reduce the perceived need to drink as a way of coping with isolation. The links between older people and social exclusion have already been recognised locally and existing community development work within the LAA is going in the right direction. The findings from this study

suggest that this type of community work and encouraging older people's engagement is useful in relation to alcohol issues.

In this context, and all others where service providers are in contact with older people who they think may be drinking heavily, there is a need to be able to discuss this with the older person to explore whether this is something they are comfortable with and feel in control of, or whether there are changes they might like to make in their lives that would obviate their experienced need to drink heavily. The scoping report indicated some reluctance to engage with older people on this issue and our experience of recruiting interviewees confirms that the topic has to be approached very sensitively. But we also demonstrate that it is possible to create a context in which older people can talk about their drinking and this study has shown the value of enabling older people to tell their own stories about the place of alcohol in their lives.

GPs are important here as they were most likely to be identified as the first source of help and we heard of some surprise at the lack of input from GPs in cases of heavy drinking. But an approach that is likely to be helpful cannot simply be framed in terms of 'safe units'. There is a need to understand the context in which drinking is occurring, the role it plays in older people's lives and what might be the consequences of stopping drinking. This needs to be combined with an approach that fulfils the duty of care that service providers have towards those who use their services. Thus recognition of older people's rights to make their own decisions about how they live their lives needs to be balanced by an ethic of care that recognises vulnerable people may need help to determine how their needs might best be met. An approach applying ethic of care principles: *attentiveness, responsibility, competence, responsiveness* and *trust*, to a process of dialogue with the older person concerned has the potential to enable the exploration of a difficult issue, and a shared decision-making approach to seeking solutions. A number of people have written about what this can look like in practice in, for example, work with older people with dementia, with carers and those they support, and in social work practice generally (eg. Barnes, 2006; Brannelly, 2006; Meagher and Parton, 2004).

However, under current arrangements GPs may not be well placed to apply these principles or considerations in their relationships with patients, and many other health professionals may be working to health targets which might detract from this kind of relationship[3]. The principles outlined in the ethic of care approach can nevertheless add an 'intelligence' to the target-driven approach to health and transform 'targets' into something that more closely resembles quality of life indicators such as, relationships, expectations, continuity, meaningfulness.

As well as contacts between sheltered housing workers, day care workers and GPs, the other context in which such explorations are needed is with those supporting older people in determining how to use individual or personal budgets. We have noted debates about whether home care workers should

[3] For example the Quality and Outcomes Framework for UK GPs introduced in 2004 whereby GPs can opt to be assessed for targets for which there are financial rewards.

buy alcohol for their clients (Herring and Thom 1997). Similar dilemmas have been voiced in the context of an approach that encourages service users to make their own choices about how to use the money allocated to them for support services. Again, we suggest that simply saying 'it's your choice' is not helpful. A dialogic and collaborative approach based in ethic of care principles is most likely to enable older people to consider and explore options that might mean that they rely less on alcohol in their daily lives.

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Appendices

Appendix 1 Steering group terms of reference

BRIGHTON&SUSSEX COMMUNITY KNOWLEDGE EXCHANGE

BSCKE Project Steering Groups

1. Context

Comprising a series of discrete community-university partnership projects, BSCKE is a highly innovative pilot funded by the Higher Education Funding Council of England (HEFCE). BSCKE supports the development of communities of practice (see Appendix) which tackle disadvantage, contribute to social transformation and bring real issues into teaching and research.

2. BSCKE Project Steering Group Terms of Reference

2.1 Function

To build dynamic and effective communities of practice, developing sustainable partnerships between people from very different institutional and cultural settings
To oversee the delivery of projects against project plans
To enable honest and self-critical reflection on partnerships and projects as they develop
To enable projects to evolve in response to emergent needs
To address challenges as they occur
To enable project learning to influence the development of relevant policies and services, at a local and national level

2.2. Membership

Each BSCKE project steering group will include the BSCKE Development Manager, community and university supervisors, the project worker/s and other stakeholders as appropriate (such as volunteers and statutory partners).

2.3. Management of meetings

To be chaired by the BSCKE Development Manager, unless otherwise agreed
To meet quarterly
To be serviced by the Cupp Project Team, unless otherwise agreed

3. Information required from BSCKE projects

HEFCE requires BSCKE to account for where funds have gone, providing details of project outputs and outcomes. The BSCKE Development Manager also needs information to enable her to provide or access support for projects. It is important to note BSCKE is not a traditional funder and we do wish to provide active support to projects as part of our role.

To identify the outcomes of work and learning at a project and programme level, BSCKE has established project steering groups, a self-evaluation framework, and a variety of Learning Forum activities. Projects are expected to work with the Development Manager to ensure that learning is shared and captured; and to share information as they progress.

The bulk of the information we require should emerge from project steering group minutes and from the process of the projects working with the Development Manager on self-evaluation. In addition, project workers will be contacted by the Development Manager to provide brief quarterly progress updates against milestones as described in the agreed project proposal. These updates will be the basis for reporting to the Cupp steering group. The purpose of this is to understand how projects are progressing and to enable us to offer practical support.

We require end of project reports (approximately 5 A4 pages) which collate and present information gleaned from the agreed self-evaluation process; and which give a financial account.

Appendix 2 Co-researchers role description

AGE CONCERN BRIGHTON HOVE AND PORTSLADE

WORK DESCRIPTION

TITLE	Researcher – Older People and Alcohol project
AIMS	To contribute to the Older People and Alcohol research project. To develop skills and knowledge of participatory research.
SAMPLE ACTIVITIES	To carry out interviews and contribute to focus groups with older people according to the agreed protocols. To keep records of interviews (either taped or handwritten) and store data according to University of Brighton guidelines. To assist in the production of a final report. To be aware of clients' limitations and to work within health and safety guidelines. To make contact with the Project Supervisor on a regular basis in order to give an update of the work and to discuss any issues of concern (for example, changes to the risk assessment or a concern about boundaries). To attend team meetings and ongoing training as required.
QUALIFICATIONS, EXPERIENCE, SKILLS, QUALITIES	Good communication skills. Good interpersonal skills. Good organisational skills. Experience of older people's issues from being an older person. Interest in and commitment to learning and developing new skills. Ability to provide regular and thorough feedback to the Project Supervisors. To be willing to examine the meanings of alcohol in your own life. Ability to be empathetic, non-judgemental and empowering whilst maintaining professional boundaries. Ability to carry out time-limited work. Ability to work as part of a team. Ability to work in a confidential way.
TIME COMMITMENT (hours, length, flexibility)	Initial training involves general induction, e-learning and other specific training related to the role. Attending team meetings and support sessions (frequency to be decided). Involvement in developing the interviews collaboratively with University researchers – expected to be three half day sessions during which appropriate training and support will be given. The research will be carried out between November 2007 and May 2008 and will involve approx five half days of focus groups, five half days of interviews and four half days of reference group meetings. Optional opportunity to be involved in the process of analysing the data.

	The research project will run until June 2008 but it is anticipated that this role will develop into longer-term involvement with Age Concern's future research.
WORK LOCATION	The ACBHP office and other public venues in Brighton and Hove. This could include travelling to the University of Brighton Falmer campus.
ACCOUNTABLE TO	Project Supervisors

BENEFITS

Out of pocket expenses
Parking costs
Other benefits associated with working for a leading local charity and the University of Brighton
Honorarium of £50 for each focus group or interview is offered
Access to organisational resources
Volunteer Newsletter
Training
Access to University of Brighton resources
The opportunity to be part of the development of community research

TRAINING

General Induction into organisation
'E' learning induction
Other
Computer skills if required
Research training as part of collaborative process of developing the research

AGE CONCERN AND UNIVERSITY'S EXPECTATIONS OF THE RESEARCHER

To understand and promote the Age Concern's policies and abide by its guidelines.
To adhere to the research project's ethical procedures.
To be responsible, reliable and safety conscious.
To work within the service parameters.
To be open and honest about any work issues or problems.
Have a genuine interest in the needs of older people.
To attend team meetings.
To take initiative in encouraging suggestions and contributing ideas to the development of the research.
To be willing to be trained on an ongoing basis.
To keep informed of other functions and activities at Age Concern.
To work professionally with volunteers and members of staff in other organisations.

Agreement

I have read and understood the above Work Description and Volunteer Handbook and would like to become a researcher.

Signature		Date	

Appendix 3 Reference group invitation

Dear

Thank you for your interest in joining our reference group for the older people and alcohol research project. Age Concern Brighton, Hove and Portslade and the University of Brighton have been asked by a group of local agencies to look into the issues related to alcohol use amongst older people as they felt there was not enough information on the needs of older people to inform the development of services in this area.

We are asking you to help us with this research by joining the reference group. This will be a group of older people (not academics or professionals) who have broad experiences and interests who would be willing to help us by acting as a sounding board for the project – by looking at ways we can approach people to discuss this issue, helping us think about the responses we get and helping us make the findings accessible and useful.

We are holding an initial meeting on Friday 14th December at 9.30am (we expect to finish by around 10.45) where we will be able to discuss with you in more detail what being a member of the group will involve, agree the terms of reference for the group (a draft of these and an agenda are enclosed with this letter) and plan future meetings. We expect the group to meet another four times during the course of the project, which is due to end in June 2008. The first meeting on the 14th December will be held at Age Concern, Prestonville Road, Brighton. We will meet travel expenses and costs, (such as carer's costs) you may incur to enable you to attend the meetings.

If you would like to join us in this project we would warmly welcome your contribution and would appreciate if you would kindly let us know if you will be attending the first meeting by calling Lizzie Ward on 01273 643903.

Kind regards,

Lizzie Ward
Research Officer

Appendix 4 Interview topic guide

TOPIC GUIDE

Interview no:
Researcher:
Postcode:

Openers

Thank you for agreeing to take part.

The things we want to cover in this interview ….

We are expecting it to take about an hour.

It would be helpful to know a bit about you and why you decided to take part.

Get them to introduce themselves – note the basic information

Male		Age		married	
Female		50 - 59		civil partner	
		60 - 69		single	
		70 – 79		partner	
		80 – 89		widowed	
		90+		divorced	
				separated	

Work status		Living environment	
Retired		Lives on own	
Semi-retired		Lives with spouse/partner	
Working full-time		Lives with family member(s)	
Working part-time		Lives with others	
Never worked		Other	
Incapacity benefit			
Unemployed			
Carer			
Voluntary work			

Housing	
Own home	
Rented private sector	
Rented housing association	
Rented council	
Sheltered housing	
Other	

How do you spend your time – can you tell me about a typical day / week?

Moving into the focus of the interview

The place of alcohol in your life.

Changes in that

- life history
- key events

Current drinking patterns

Where?

When?

Who with?

What?

How much?

Why?

Role of alcohol now?

Enjoyment or otherwise

Do you like drinking - at the time

Impact

Health

Finances

Relationships

Help Seeking

Do they feel they need help?

Have they ever sought help?

Would they seek help again? If not, why? If so, who from?

Responses to people asking about drinking.

Is it difficult to talk about?

Is there anything that might make drinking less important?
Other things they think?

Other things you think are important that we haven't talked about?

Do you think your experiences are similar to others?

Closing

What might you want to see happen as a result of this research?

Thank you for talking about this.

Explain what next – we will send you a summary of interview to check and would like to send a voucher as a thank you.

What would be useful
Boots
Tesco
Sainsburys

My reflections on the interview

Appendix 5 Co-researcher training manual

Older People and Alcohol Project

Co- Researchers' Training Manual

Notes taken on co-researchers training sessions January 2008
Health and Social Policy Research Centre, University of Brighton

What are we trying to understand in this project?

We made the following points in our discussion:

- Gaps in services – what would help people if they have a problem?
- The reasons why people drink?
- Different reactions to transitions, e.g. bereavement, retirement
- Who might the person talk to?
- Gaps in bereavement services in first few months of bereavement
- Checking out the scoping study perceptions with older person's 'truth'
- How older person experiences ….
- Positive / social aspects of drinking and social interaction
- What does drinking mean to person?
- Is there a tipping point when it becomes a problem?

Ethics

The principles of research ethics are based on three areas:

Confidentiality – people share information on their lives, experiences and feelings and these must remain confidential to the research team.

Trust – we create trust to encourage people to open up so we need to be worthy of that trust, e.g. by treating material confidentially.

Respect – be aware of how you react to what people tell you – you may not agree with them or you may disapprove of what they say but remember it is important to them.

Be aware of how people are responding to being researched and understand how your intervention is affecting them at the time and afterwards.

Research relationships and power

- People are opening up and giving you information and you are taking it away and using it.
- Power not all one way – they may be using the interview for some reason.
- Ultimately researchers have power in making decisions about the project and in writing up.
- We must not be exploitative – during the interview and in our approach – are there things they think are important that we haven't asked about?
- After the interview we will provide them with a written summary and they have the right to withdraw their consent.
- They will receive a copy of the final report.

Key issues in successful interviewing

We made the following points in our discussion of what makes a successful interview:

- Not having pre-conceived ideas
- Leading the interviewee back to the subject you want to talk about
- Creating a safe and comfortable atmosphere – putting interviewee at ease
- Not expressing your own opinions or being opinionated
- The 3 Cs -
    - Contact – introduce yourself to put the person at ease, e.g. look for something to comment on
    - Content – questions
    - Close – summary and indicate what might happen next
- Being able to contain what happens – an appropriate boundary while allowing person to express themselves
- Own sense of self and confidence
- Listening actively – open questions
- Managing empathy, showing humanness – demonstrate interest and concern without taking on board the problems
- Not showing your feelings on face or body language
- Don't indicate you are making a judgement
- Conversation with a purpose – arranged and planned
- Natural language
- Keep professional hat on
- Balance between being natural and achieving your purpose
- Go prepared – emotionally and practically. If in persons home be prepared for interruptions

Reactions to interviewing

We may feel nervous but need to be aware that person being interviewed may also be nervous. Highlights the importance of being on top of what you are doing and being familiar with the topic.

Their feelings may be:

- Will I be judged as bad?
- Concern that their house is tidy – it may have deteriorated
- They may expect you to advise or help.
- They may suspect you of trying to get them into care and suspicious of who sent you.

Being aware of your own feelings:

- Uncomfortable – you may want to get out but you have a responsibility to give them your attention.

- Feeling sorry for them – the need to realise that as a researcher you are not there to solve their problems.
- Own reactions to ageing (maybe in bad circumstances) it can be upsetting and bring thoughts about own parents or in relation to alcohol. Put this to one side at the time and focus on what you are there for.
- Be accepting without disclosing why you understand how they feel – empathy without sharing your experiences with them.

After the interview de-brief with Lizzie – Lizzie (and Marian and Bea) to provide support when needed.

Structuring the interview

We are taking a broad approach and using semi-structured interviews because we know broadly the issues we want to understand but nature of the topic means that tightly defined questions could appear like an interrogation.

We will be using the topic guide – the order of the questions will vary according to what the person is saying. It is important to cover all the topics. If the person starts to talk about a topic you follow. There may be issues that are important to the person that are not in the topic guide – at the end of the interview invite the person to tell us anything they think is relevant.

Remember your own safety – if the person is drunk arrange to come back.

Seek clarification – if the person is talking in the third person are they talking about themselves or others. Be aware of potential memory problems (rambling).

Make sure you get the basic personal data – age, gender, marital status, living circumstances, housing tenure, and work status. These will be listed in the topic guide with tick boxes to help you. You can use these at the beginning of the interview and check back at the end to make sure you have them all.

Technical skills

Starting the interview

- Introduction – try and find something to comment on as an icebreaker:
- I've never been to this bit of Brighton before …

- Try to create the interview environment – if it is in their home need to make the environment conducive:
- Important that the TV or radio is not on.
- Are there other people in the room? Ideally get the person on their own unless the person specifically asks for someone else to be there – in

the initial letter from us it will say ‘we would like to talk to you on a one-to-one basis’.

- Locate yourself for eye contact but with enough distance between you.
- Locate somewhere to put the recorder so that it can pick up both your voices. This may mean asking if you move stuff around.

Ethical procedures and gaining consent

You must ensure that you have their formal consent. They will already have been sent the Information for Participants sheet but take another copy with you and go through it. You don’t have to read it word for word but use it as a prompt to explain and do make sure they understand the 1st and 2nd paragraphs of the sheet:

- Go through the consent form and get them to sign. The point on What it is you are there for
- Who is doing the research
- Why we are doing it
- That we want to talk to them about their own experiences
- Indicate how long it will take
- Make it clear they can stop at any time
- Stress the confidentiality and the information will be shared amongst the research team. Explain that the only reason we might talk to a third party is if the information they gave raised serious concerns for the safety or well-being of a vulnerable individual and this is because Age Concern is a project partner and we have to follow their guidelines.
- Explain that we will be writing a report – their name or personal details will not appear but we may ask to use quotes.
- We will send them a copy of the report.
- possible risks refers to the risk that they may get upset. Explain that if they do get upset we can stop, we can have a pause and come back later. Make sure they know what they are signing and have agreed to have the interview recorded. – but they can ask to have the tape turned off.
- The consent form needs to be returned to Lizzie.

Note taking and recording

When gaining consent for recording the interview explain that it makes it easier for us to listen to what they are saying and have an accurate record of the interview.

Try and take notes as well – in case it hasn’t recorded – jotting down key words or phrases. Try and indicate in your notes if it is verbatim with quote marks. After the interview as soon as you can write down your own reflections and impressions. Quite often people say interesting things after you’ve closed the interview and switched off the tape – if this happens you can acknowledge that it is relevant / interesting and that you would like to include it.

Practical issues:
Are the batteries ok – make sure you have spare ones.
Is the recorder switched on? Beware that it is not on pause and make sure you can see from the numerical counter that it is recording.
Is the mic switched on or close enough to be picking up – check the recording level.

[Separate training will be done around the specific recorders we will be using on the operating instructions]

Prompts without leading

- Avoid leading questions that contain an assumption, or framed in a way that you have answered the question, such as …
- do you have a problem keeping the house clean … you must be finding it a struggle?
- would you say that …
- what health problems does alcohol cause you?

Stay neutral:

- Does alcohol have any impact – rather than 'what impact?'
- has your pattern changed?

Our responses

- Make sure you are not conveying judgement – use opening up questions:
- can you tell me more about ….?
- could you clarify ….?

Check your body language

- do not convey look of shock.
- indicate interest and focus your attention on them – don't show boredom or disinterest.
- can use sympathetic noises.

Responding to something 'criminal' or damaging behaviour or suggests adult abuse

- Repeat what was said to clarify – so has anything changed? Is this currently happening?
- Ask – have you spoken to anyone else about this? Are they receiving help already?
- If serious concerns then remind the person of disclosure guidelines from consent form … I feel I will need to talk to my team about this …
- You will be leaving them with contact details for advice and information.

Listening
Key points:

- Listening to what the person is saying is important so that you can use what they have said to shape subsequent questions and structure the interview.
- Be aware of the difference between listening and interpreting, e.g. the presenting problem and the underlying problem.
- During the interview listen rather than interpret – interpreting comes later at the analysis stage. The recording of the interview has to make sense … is there a gap there? … is there any issue of who is being referred to?

Monologues
Key points:

- If the person is going off at a tangent –don't follow their lead.
- Don't interrupt but try and spot the opportunities to intervene by asking for clarification to take it back to focus.

Distress and advice
Key points:

- Remember that distress is 'normal' and not to be avoided.
- Offer a break.
- Be sympathetic but within boundaries.
- You will be leaving a list of contact numbers for advice.
- You cannot make referrals to agencies but with their permission you can ask agencies to call them.

Closing the interview

- See the last page of the topic guide. Let the person know what will happen next:
- We will send them a written summary of the interview for them to check and add to if they wish.
- Ask them about which shopping voucher they would prefer and explain that this will be sent to them.
- The final report will be sent to agencies to help them in delivering support and advice.
- They will be sent a copy of the final report.

Points that came out of role play

- Be aware of not getting into advising / counselling role.
- Keep your researcher hat on.
- Good to repeat what the person says for follow up questions or clarification e.g. 'so when you say you drink …'
- Be aware of not using leading questions – change 'so you've never had any problems' to 'so have you had any problems'.
- Clarify the basic info – we will design a short questionnaire to record details of the interviewee.
- Remember you can depersonalise by saying …'in this interview we have to cover all aspects … if these things aren't relevant bear with me'.

- Be flexible with topic guide … move questions around if they naturally come up. To be able to do this you must be clear in your mind what you are trying to find out.
- Be aware that the person might say something that reminds you of your own family or personal situation – important to stay neutral and remember you are not their son/daughter /sister etc.
- Don't make statements or opinions e.g. 'Do you not feel you should tell your doctor?'
- Try and make it OK for them to say anything.

Appendix 6 Participant Information Sheet and Consent Form

Cheers!? A project about older people and alcohol
Information for participants

The University of Brighton along with Age Concern have been asked to do some research into older people's experiences of alcohol. This is because local agencies who provide services for older people are interested in learning more about this to help them think how they might provide help where this is necessary.

We would like to talk to you about your own experiences of alcohol and we will be asking things such as do you prefer drinking alone or with friends, what do you enjoy about drinking, how do you feel about drink and has drinking every worried you. We will want to talk to you for around an hour but want to stress that you are free to finish the conversation at any point without giving a reason. We would like to record the conversation as this will help us make sure we have properly understood what you say. After the interview we will send you a summary.

After we have collected people's experiences and stories we will produce a report for the local agencies who will use it to help them to gain a better understanding about the issues and inform the development of services for older people.

We will ensure that everything you tell us will be treated in the utmost confidence and we will not pass information on to anyone else. The only exception would be if this information raises serious concerns about the safety or well-being of a vulnerable person and then we would need to contact somebody who can help. Your name or details that would identify you will not appear in the report, although with your permission we may ask to reproduce something you have said as an example. We will send you a copy of the final report.

We can visit you at home or arrange to talk to you at another location if you would prefer. We will cover your transport costs or any other costs you may incur, for example, if you look after someone and need to arrange care for them while you are talking to us. We would also like to offer you a £10 voucher as a thank you for sharing your experiences with us.

The main researcher on this project is Lizzie Ward. If you would like to talk to Lizzie you can call her on 01273 643903. If you would like to speak to someone who is independent of the study you can contact David Wolff who is the Director of the Community University Partnership Programme at the University of Brighton on 01273 642401.

Cheers!? A project about older people and alcohol

Consent Form

- I agree to take part in this research which is to gain understanding of older people's experiences of alcohol.
- The researcher has explained to my satisfaction the purpose of the study and the possible risks involved.
- I have had the principles and the procedure explained to me and I have also read the information sheet. I understand the principles and procedures fully.
- I am aware that I will be required to talk about my own experiences and answer questions.
- I understand that any confidential information will be seen only by the researchers and will not be revealed to anyone else. But if this information raises serious concerns about the safety and well-being of a vulnerable person we will need to contact somebody who can help.
- I understand that I am free to withdraw from the interview at any time.
- I agree to the interview being recorded.

Name (please print)…….……..
Signed.....
Date.....

Name of Researcher ……..

Appendix 7 Reference Group terms of reference

Age Concern Older People and Alcohol Project

Older People's Reference Group

Terms of Reference

The Role of the Reference Group
The reference group is intended to enable an active partnership between older people and researchers throughout the study. The group provides an opportunity for older people with varied experience to contribute to and influence the research through:

- Bringing together the views and opinions of people with different experiences in relation to older people and alcohol use.
- Highlighting and advocating any issues that older people may identify which may relate to gender, ethnicity, culture, sexual orientation or age.
- Offer advice on the proposed research methods from older people's perspectives.
- Sharing ideas and information while ensuring the confidentiality of the research and any other information shared by the researchers or other members of the group.
- Commenting on any findings and making suggestions about making the research accessible and useful.

The research team will ensure the following:

- Research questions and methodology, are explained and summarised in a clear, jargon-free and concise manner.
- Information will be written in an accessible format.
- Members of the group to be kept up to date with progress of the research.
- Members' views and suggestions will be valued.
- The analysis and findings are explained and summarised in a clear, jargon-free and concise manner.
- Papers and information to be discussed at meetings will be sent out prior to meetings.
- That travel and care expenses will be paid for attending the meetings.

Membership
Older people have been invited to join the reference group to reflect a variety of experiences, locations and interests. Although some members are also members of other older people's groups they are members of the reference group as individuals rather than representatives of those groups, ie they are not expected to speak on behalf of other older people.

Management of meetings

- To be chaired by the Research Officer, unless otherwise agreed.

- The group is expected to meet four times during the course of the project (but additional meetings may be arranged as necessary and by agreement with the group). Each meeting is expected to last around two hours.
- The meetings will be arranged and serviced by the Research Officer, unless otherwise agreed.

Appendix 8 Participant flyer

Cheers!?

A project about older people and alcohol

Most of the attention given to alcohol focuses on young people. But what about older people? Is drinking a problem for older people? Or is it something they enjoy? The University of Brighton along with Age Concern have been asked to research into older people's experiences of alcohol and we would like you to help us with this project. Local agencies are interested in learning more about this to help them think how they might provide help where this is necessary.

We are mainly interested in learning about drinking habits amongst people who are post retirement, but we would also like to talk to people in their 50s. We are hoping to get some people together to discuss this in small groups as well as to speak to people individually about their own experiences. It will be in confidence and no names will appear in the final report.

We really need your help. If you would like to find out more about this project or are interested in taking part please get in touch by calling Lizzie Ward at Brighton University on 01273 643903.

You can also contact Lizzie by email - e.ward@brighton.ac.uk or by completing the tear-off slip below and returning to us FREEPOST.

This research is taking place between January and June 2008 so a prompt response would be appreciated.

Please complete the following and return to **FAO BG –AA Age Concern Brighton Hove & Portslade, FREEPOST BR2073, Brighton BN1 3BR**

Name……

Address ……

……Phone …….

Appendix 9 Biographical details of participants

The names of all the participants have been changed

IV no	Drinking Style	Name	Biographical details
Pilot	3 & 4	BILL	Is a single man in his early 60s. He lives on his own in council sheltered housing and because of ill health relies on Incapacity benefit. He fits primarily fits drinking style 4 although sometimes 3
1	1 & 2	CHARLES	Is a widower in his early 80s. He described himself as semi-retired and lives on his own in his own house. He fits style 1 as he has a small beer usually every lunchtime but say's he rarely finished the whole drink and prefers orange juice
2	1	ANGELA	Lives with her husband in their own home and is in her 60s. She is retired but does voluntary work. She fits style 1 as she drinks wine every evening with her meal.
3	2	LINDA	Is in her 60s and is divorced. She lives on her own in housing association property. She fits style 2 and only occasionally has a drink as part of her social life
4	3 & 4	IAN	Is single in his fifties. Because of ill health he depends on incapacity benefit and lives on his own in council property. He has drunk heavily all his adult life and fits style 3 but also drinks with friends, some of whom are heavy drinkers
5	2	JACK	Jack is divorced in his seventies and lives on his own in council sheltered housing. He fits style 2 and likes to drink brandy occasionally
6	3	LARRY	Is a retired man in his early seventies. He is divorced and lives on his own in a council flat. He fits style 3 as he drinks every day on his own but

			does occasionally go out for a drink with a friend
7	1	CHRISTINE	Is retired and in her sixties. She lives with her husband in their own home. She fits style 1 as she drinks a couple of glasses of wine every day with her evening meal
8	4 & 3	ANDY	Is in his fifties and lives in a hostel. He is unemployed and has been a street drinker for a number of years. His long term partner also drinks heavily. He fits style 4 and belongs to a community of drinkers but will also drink on his own.
9	3	KATIE	Katie works part-time and is in her late fifties. She lives with her husband in their own home. She fits style 3 as she drinks on her own everyday
10	3	TOM	Is a widowed man in his eighties. He lives on his own in council sheltered housing. He fits style 3 because of health problems he has difficulty leaving his home.
11	1 & 2	LES	Is in his early 60s and works full time. He lives in council accommodation with his wife. He fits style 1 as likes to have a drink every evening with his wife but tries to have days off from having a drink.
12	2	JOHN	Is retired in his seventies and lives in housing association sheltered housing with his wife. He fits style 2 as occasionally drinks beer or wine in company
13	2	LILY	Is a widow in her eighties. She lives on her own in her own home. She fits style 2 and drinks when she lunches with friends. She occasionally has a drink on her own as ‘pick-me-up’
14	3 & 4	TOBY	Is in his mid seventies, divorced and lives on his own in council sheltered housing. He crosses style 3 and 4 and he drinks on his own but mainly in pubs although does drink at home occasionally

15	2	SUE	Is a widow in her eighties who lives on her own in her own home. She fits style 2 as she will have a glass of wine on social occasions
16	1	HENRY	Is in his late seventies and lives with his wife in their own home. He fits style 1 as he likes to drink wine every evening with his dinner
17	2	BEN	Is in his fifties and lives with his wife in council housing. Because of ill health he relies on incapacity benefit. He fits style 2 and because of his health condition can only have an occasional drink
18	2	JOANNA	Is in her fifties and lives with her husband in council accommodation. She fits style 2 and only very occasionally drinks in social situations
19	1	JANE	Is in her fifties and works part-time. She lives in her own home with her husband. She fits style 1 as she drinks a glass of wine every evening with her meal.
20	4	MARK	Is single and lives on his own in council sheltered housing. He fits style 4 although health problems have forced him to moderate his drinking. He only drinks when he is out with his friends.

Day Centre Focus Group (7)	BME Focus Group (7)	Women's Focus Group (5)
JENNY	ANITA	SONIA
HANNAH	EDDIE	LOUISE
DOREEN	SAMIRA	WINNIE
JOAN	MARIA	MAGGIE
STEPHEN	JACKY	SANDRA
BETTY	CLIVE	
BOB	REENA	