

2015 to 2020

Evaluation of the Drink Wise, Age Well Programme



FOREWORD

We have known for some time that alcohol consumption and harm is increasing more in the over 55s than in any other age group. Throughout the countries of the UK the evidence is that 55-64 year olds drink more on average than any other age group and are the most likely to exceed the UK drinking guidelines. Recent ONS analysis shows that alcohol-related deaths in the UK are highest in the 55-64 year old age bracket and have increased significantly in the over 65s in the past 20 years.

In 2014, We are With You (then Addaction) invited a group of expert partners to join them in a proposal to the National Lottery Community Fund to address this growing concern. The Rethink Good Health Fund aimed to reduce alcohol harm in the over 50s, and influence policy and practice.

Together with Developing a Caring Wales, ILC-UK, Royal Voluntary Service, Addiction NI and the Substance Misuse and Ageing Research Team (SMART) from the University of Bedfordshire, We are With You secured the £25 million fund to deliver the Drink Wise, Age Well programme across five intervention areas in England, Scotland, Wales and Northern Ireland.

The programme was designed with the knowledge that older adults and professionals who support them had low levels of awareness around alcohol harm in an ageing population.

Alcohol problems in older adults can often go undetected and life transitions such as bereavement, retirement and loss of sense of purpose can be key drivers for increased alcohol use. Further research also found a high level of stigma and discrimination in relation to alcohol and ageing.

The programme aimed to address these issues - challenging stereotypes, raising awareness, reaching more hidden older drinkers, and delivering interventions that focus on building resilience and social connection.

I am very proud of the impact the programme has made. Drink Wise, Age Well reached over 60,000 people in the communities it served and importantly can demonstrate its positive impact for those communities.

This report presents the key findings from the academic evaluation of the programme. Using a Contribution Analysis method the research team found the programme had impact in four areas: increasing knowledge, awareness and profile of the issue; increasing resilience; supporting people to make changes to their alcohol use; and reducing stigma and discrimination.

This report shows how the programme supported people who may otherwise have remained hidden. The value placed by programme participants on non-judgmental and person-centred support shows that this should be integral to alcohol treatment.

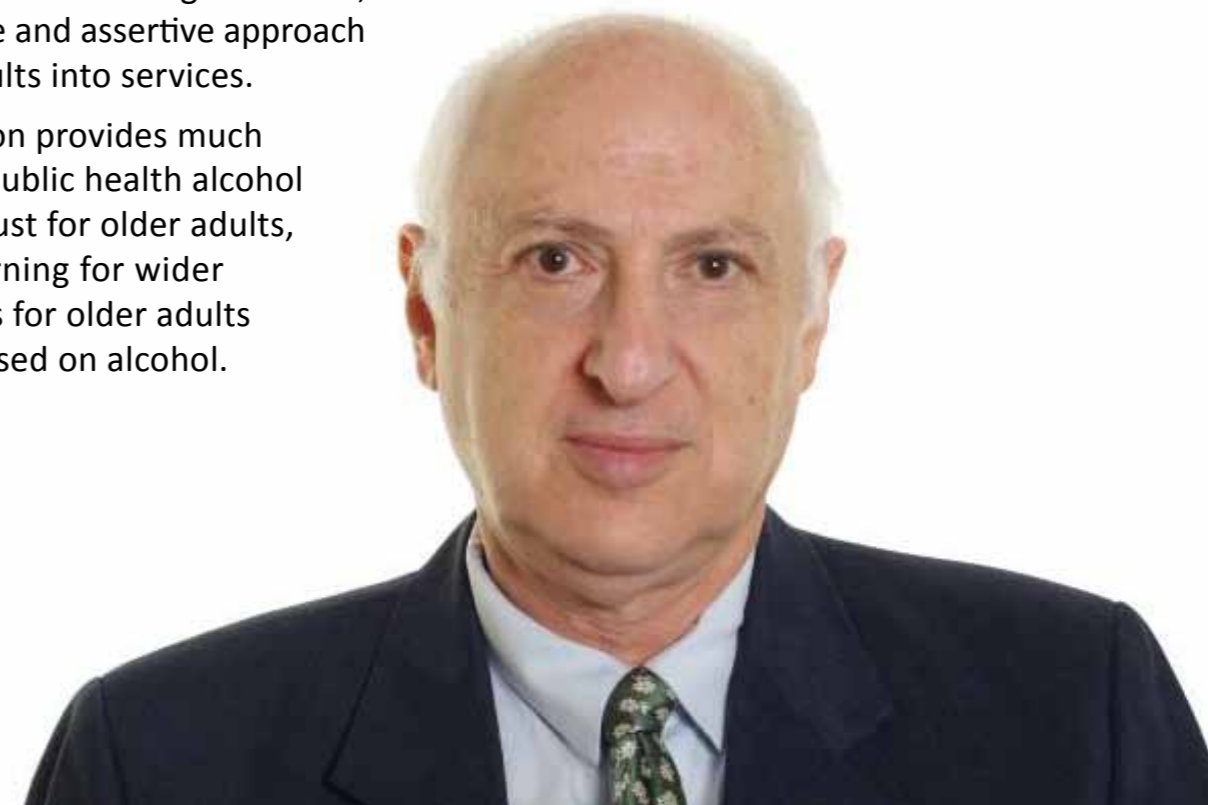
The report also shows that we cannot treat alcohol problems in older adults in isolation; we must address the wider social, environmental and psychological causes that can lead to increased alcohol use. It calls for improved screening and recognition of problem drinking in older adults by health and social care professionals, and that alcohol treatment services are age-inclusive, adopting a proactive and assertive approach to engage older adults into services.

Finally the evaluation provides much learning for wider public health alcohol interventions, not just for older adults, and conversely learning for wider wellbeing strategies for older adults that is not just focused on alcohol.

I hope to see the recommendations in this report applied across the planning and commissioning of alcohol services, the delivery of alcohol treatment and the shaping of alcohol policy so that going forward we may see the same reversing trends on alcohol harm among older people as we currently achieve with our younger population.



Lord Alex Carlile
Chair of Trustees, We Are With You



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INTRODUCTION

HISTORY AND CONTEXT

Historically, alcohol problems were described as a self-limiting condition with an early-life onset that ended in either abstinence or death before old age was reached.^[1] Researchers challenged this view in the last quarter of the twentieth century as it became evident that not only did some older adults continue alcohol problems developed earlier in life into old age, some people actually developed a problem with alcohol for the first time in later life.

In 1974, Zimberg^[2] concluded that late-onset alcohol problems were a “cry for help” against loneliness, depression, feelings of hopelessness and “the stresses of ageing”. In the years that followed, other studies, most of them carried out in North America, backed the early conclusions of Zimberg.^[3-7] Different categories of older adults with alcohol problems were identified; potentially requiring different intervention approaches.^(see Figure 1)

CATEGORIES OF OLDER ADULTS WITH ALCOHOL PROBLEMS^[8]

MAINTAINERS

- Have continued their previously unproblematic use into old age
- Age-related changes in metabolism may result in harms later in life

SURVIVORS: EARLY-ONSET USERS

- Make up two-thirds of older problem drinkers
- Have a history of substance use which persists into old age
- Often have co-morbidities

REACTORS: LATE-ONSET USERS

- Problems began in 50s or 60s
- Associated with stressful events e.g. bereavement, retirement, relationship breakdown or social isolation

(Figure 1)

In 1998, the United States (US) Substance Abuse and Mental Health Services Administration Centre for Substance Abuse Treatment published its first Treatment Improvement Protocol on Substance Abuse in Older Adults^[9] which was revised at regular intervals until 2012. The protocol recommended that older adults should be ‘treated in age-specific settings where feasible’. By 2003, a study of both public and private treatment centres in the US found that 18% had special older adults’ services^[10] and by 2011, 20% of private substance misuse treatment centres in the US offered specialist services for older adults.^[11] Evidence found that these older adults’ services were linked to better treatment outcomes than mixed-age services.^[12-16] As time went on, other countries such as Australia and Canada started calling for age-specific alcohol and drug services e.g.^[8, 17]

In the United Kingdom (UK), alcohol treatment is mostly provided by non-governmental and non-profit organisations with a combination of public and charitable funding. By 2011, there were five substance misuse treatment services which had an older persons’ service, three of which were in England, one in Northern Ireland and one in Scotland.^[18] The first of these services, Addiction NI Older Focus Service, was established in Belfast in 1997, the other services were established after 2010. A number of these services had received funding from the National Lottery Community Fund (previously the Big Lottery Fund), a non-departmental public body responsible for distributing funds raised by the National Lottery for “good causes”.

In 2006, initiated by the Public Health Institute of Scotland, the Alcohol and Ageing Working Group published a report ‘Alcohol and Ageing: Is alcohol a major threat to healthy ageing for the baby boomers?’ The report concluded that if baby boomers¹ carried their current drinking patterns into old age there could be a dramatic increase in alcohol-related hospital admissions, something which would create serious difficulties for the NHS.^[19] In 2011, a report, written by the UK’s Older People’s Substance Misuse Working Group of the Royal College of Psychiatrists, warned that not enough was being done to tackle substance misuse in our ageing population – making them society’s “invisible addicts”.^[20] The same year, the University of Bedfordshire’s newly established Substance Misuse and Ageing Research Team (SMART) published the Working with Older Drinkers report.^[18] The report made a number of recommendations based on a literature review and research interviews with older adults attending age-specific substance misuse services and the practitioners who worked with them. It concluded that “specialist older peoples’ services may have an important strategic role to play in this area and offer additional benefits in terms of treatment to mainstream services”.

In the last decade, media and alcohol policy in the UK has disproportionately focused on binge drinking in young people presenting a picture at odds with epidemiological evidence. Among young people, broadly speaking, binge drinking (and drinking in general) has declined since the late 1990s but alcohol consumption has increased among people aged 55 and over, with the greatest increase seen amongst older women. In England and Scotland, it is those aged 55-64 who are most likely to exceed the recommended weekly alcohol guidelines. The turn of the century saw acknowledgement that action in relation to alcohol harm was required at all stages of life. The Substance Misuse Strategy for Wales 2008-2018 recognised the importance of addressing “the particular needs of older people” and the Northern Ireland “New Strategic Direction for Alcohol and Drugs: Phase 2, 2011-2016” identified “older people drinking hazardously, dangerously or dependent on alcohol and/or addicted to/misusing drugs” as a key priority. Older adults were mentioned in the UK Government’s 2012 Alcohol strategy (although statistics on drinking were only provided for young people and adults aged 25-64). There was no mention of older adults in the 2009 alcohol strategy for Scotland.

By 2013, the National Lottery Community Fund, through its funding of specialist older adults alcohol services, had recognised that alcohol misuse in older adults was an area of unmet need. It advertised for an organisation to lead, manage and deliver a new £25 million UK-wide programme, Rethink Good Health, to “tackle late onset of alcohol misuse amongst older people”. Rethink Good Health’s aims were to inform policy and practice about preventing alcohol dependency in later life; improve the health and wellbeing of people aged 50 and over who are at risk of developing alcohol dependency and inform more effective service delivery to prevent alcohol dependency amongst an ageing population”. The lead partner was expected “to develop an overall strategy and manage a portfolio of around 15-20 individual projects across the UK that either replicated existing projects that had demonstrated impact or were new projects which demonstrated innovation in this area”.

In 2014, a strategic partnership of six partners; Addaction (now We Are With You, the lead organisation), Addiction NI, Drug and Alcohol Charities Wales, the Royal Voluntary Service, the International Longevity Centre and the Substance Misuse and Ageing Research Team at the University of Bedfordshire were awarded the funding to develop and implement the programme which was named ‘Drink, Wise, Age Well’.

In total, eighteen organisations were involved in the implementation delivery, research and evaluation of the programme. In the same year, the World Health Organisation identified alcohol-related harm among older adults as an increasing concern.^[21]



¹ The term ‘baby boomers’ refers to the considerable rise in birth rates that occurred following the end of World War II.

THE DRINK WISE, AGE WELL PROGRAMME

The Drink Wise, Age Well programme was delivered over five years from 2015 to 2020 in five intervention areas across the UK; (Sheffield and Devon in England), Glasgow in Scotland, Cwm Taf in Wales and the Western Trust Area in Northern Ireland. These areas were selected as they presented specific challenges (e.g. high levels of alcohol use, deprivation, rurality and a high proportion of Black, Asian and other minority ethnic groups who are under-represented in alcohol services).

The over arching aim of the programme was to reduce alcohol harm in older adults. Older adults were defined as people aged over 50. Old age comprises the later part of life; the period of life after youth and middle age. The age at which old age is considered to begin differs according to the context. In the alcohol research literature, an ‘older’ person is usually someone aged over 50. This is because the ageing process among people with chronic alcohol and other drug problems can be accelerated by at least 15 years. A low age cut-off also enabled the programme to deliver preventive interventions before people retire from work. Retirement is a major life transition which can pose challenges to some people as they find it difficult to adjust to their new role and circumstance. It can lead to increased alcohol use and the development of alcohol problems.

THE PROGRAMME HAD 4 OBJECTIVES

1	To raise awareness of the issue of alcohol misuse among people over 50, change attitudes, reduce stigma, convey harm reduction messages and influence community norms about the use of alcohol.
2	To increase individual and community resilience to alcohol problems in people over 50 and to reduce hazardous, harmful and dependent drinking and related harm in this age group.
3	To increase the extent to which community service providers and employers who have regular contact with people over 50 are able to recognise and respond to risky drinking.
4	To develop a body of evidence on how to prevent alcohol misuse in people over 50 which will inform future prevention work in the UK.

Drink Wise, Age Well targeted the general population and people over 50 at increased risk of, or experiencing, alcohol problems. There was a tiered continuum of interventions of increasing strength but narrowing reach ranging from the use of the mass media to educate the public about the harms of risky drinking in later life to intensive interventions for people with alcohol problems. The programme had a number of defining features:

Age-specific focus: people aged over 50.

Population-level approach: targeting the general population, people over 50 at increased-risk, people over 50 experiencing alcohol problems and their families.

Multi-level: including individuals, groups, organisations and communities.

Multicomponent: more than 40 interventions.

Tailored response: tailored to address the specific needs of local communities and sub-populations.

Engagement of broad array of community organisations: such as healthcare providers, police, employers, trade unions, housing organisations, police, fire service, care homes, hairdressers and local alcohol commissioners.

Mobilisation of over 50's with lived experience of alcohol problems: to influence practice and policy change.

Programme participant choice: in terms of drinking goals (e.g. abstinence versus a reduction in drinking²), type or combinations of intervention (e.g. one-to-one vs group format, one-to-one vs with significant others), focus of interventions (focused on alcohol vs non-alcohol focused interventions) and setting (e.g. at home or in a health centre).

Drink Wise, Age Well was delivered during a period when alcohol services were “in crisis” as a result of cuts in public funding, rapid re-tendering cycles, loss of qualified staff and lack of political support^[22] and fall in the numbers of people in treatment for alcohol problems.^[23] A Public Health England inquiry found that financial pressures, service reconfiguration and reduced capacity were largely to blame for the reductions in the number of people receiving treatment.

As the programme was drawing to a close, Minimum Unit Pricing (a minimum price under which a unit of alcohol cannot be sold) was introduced as a national policy in Scotland (in May 2018) and Wales (in March 2020) but not in England or Northern Ireland.

² The choice of drinking goal may have been limited depending on the severity of problems

METHOD

The evaluation was carried out by the University of Bedfordshire (England, the lead academic partner), Glasgow Caledonian University (Scotland), Wrexham Glyndwr University (Wales) and Queen’s University Belfast (Northern Ireland).

THE OBJECTIVES OF THE EVALUATION WERE TO:

- 1 Determine whether the programme is working well and whether it could be improved (formative evaluation)
- 2 Measure impact and effectiveness (summative evaluation)

CONTRIBUTION ANALYSIS

The findings of the summative evaluation are described in this report. These findings are based on an approach called Contribution Analysis.

Contribution Analysis helps to assess the impact (contribution) of programmes where changes are likely to be the result of multiple contributory factors. The aim of Contribution Analysis is to produce a credible, evidence-based narrative of contribution that a reasonable person would be likely to agree with, rather than to produce conclusive proof (e.g. a reduction in alcohol-related hospital admissions).

THE QUESTIONS WE SET OUT TO ANSWER WERE:

- 1 What was the reach and impact of the interventions?
- 2 How did they bring about change?

This Contribution Analysis was carried out in Year 4 of the programme and involved the following stages:

- 1 Conducting workshops with staff and programme participants in each intervention area to understand what they set out to achieve (objectives) and how (activities).
- 2 Based on the findings of the workshops and relevant research, developing results chains (logic and theory of change models³) showing the mechanism of change and key areas of impact.
- 3 Meeting with staff to clarify our understanding of the logic and theory of change with view to refining both.
- 4 Consulting research literature to explore whether the logic behind the key areas of activity was appropriate, including examining the basis of any theoretical assumptions made.
- 5 Gathering existing evidence⁴ that each of the different links in the results chains (activities and outcomes) occurred, assessing the quality of the evidence and gathering additional data to fill in any gaps.
- 6 Developing contribution narratives describing how each key area of programme activity was implemented and brought about change.

A planned quasi-experimental study which involved a ‘before’ (pre-test) and ‘after’ (post-test) survey of people living in the intervention and matched control areas had to be abandoned because restrictions imposed to control the Covid-19 pandemic made carrying out the post-test survey impossible.



³ A logic model is a graphic which represents the theory of how an intervention/programme produces its outcomes. It represents, in a simplified way, a hypothesis or ‘theory of change’ about how an intervention/programme works.

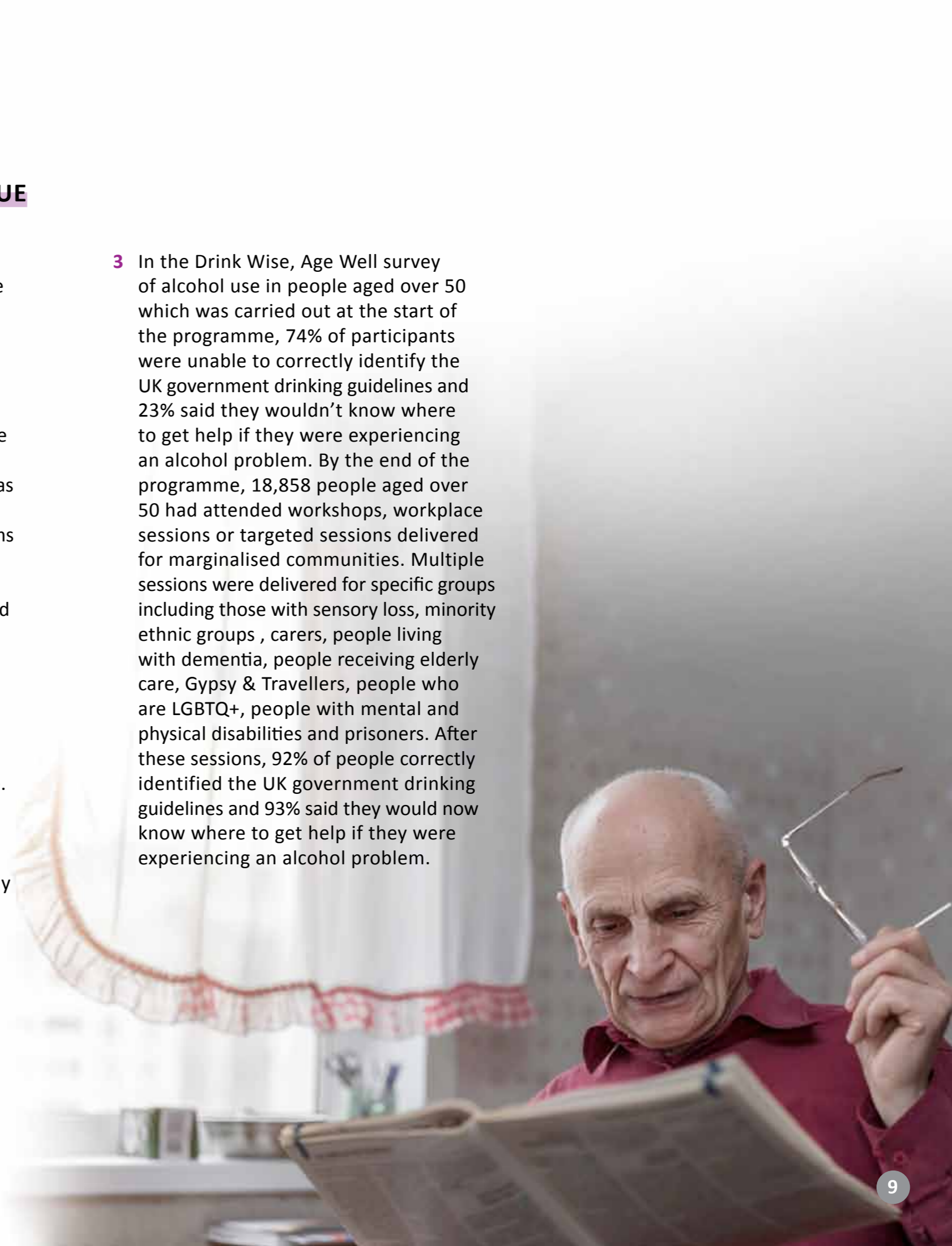
⁴ We examined reports, literature and routinely collected data produced by Drink Wise, Age Well, our own independent research reports and the data we had gathered from programme participants, staff and professional stakeholders in the intervention areas over the five years of the project.

KEY FINDINGS: REACH AND IMPACT

INCREASING KNOWLEDGE, AWARENESS AND PROFILE OF THE ISSUE

- 1 Drink Wise, Age Well used media advocacy⁵ and information to promote wide exposure of programme messages and draw people into the programme. These included national and local newspaper, radio and television coverage, informational flyers distributed to members of the public at community events and informational mailings to family households. These activities reached a significant number of people. For example, more than 15 million people were potentially exposed to media messages about the Drink Wise, Age Well survey of alcohol use in older adults in the first year of the programme. In the month following the coverage, 1,332 more people sought information, help or advice from Drink Wise, Age Well than in the previous month (an increase of 187%). Drink Wise, Age Well distributed more than 60,000 information leaflets or interactive materials (e.g. alcohol unit measuring cups). The programme had a significant online and social media presence. By the end of the programme, there were 834,000 Twitter impressions, 212,643 people had viewed the programme's Facebook content and more than 120,000 people had visited the Drink Wise, Age Well website.
- 2 Drink Wise, Age Well invested considerably in building the knowledge and skills of the wider workforce. By the end of the programme, 9,570 professionals from over 150 different organisations including police, the fire and rescue service, Citizens Advice Bureau, the NHS, trade unions and care homes had received Drink Wise, Age Well training. The aim of the training was to improve the way that professionals identify and respond to alcohol problems in people aged over 50. 90% of people who attended said they planned to make changes to their practice, 92% said they had an improved understanding of age-specific issues and 97% reported that their knowledge of the subject had improved. One of the most common changes people said they would make was to have more conversations with people aged over 50 about alcohol use. Drink Wise, Age Well training is now mandatory for staff delivering alcohol treatment for the service provider We Are With You that works extensively across England and Scotland.
- 3 In the Drink Wise, Age Well survey of alcohol use in people aged over 50 which was carried out at the start of the programme, 74% of participants were unable to correctly identify the UK government drinking guidelines and 23% said they wouldn't know where to get help if they were experiencing an alcohol problem. By the end of the programme, 18,858 people aged over 50 had attended workshops, workplace sessions or targeted sessions delivered for marginalised communities. Multiple sessions were delivered for specific groups including those with sensory loss, minority ethnic groups, carers, people living with dementia, people receiving elderly care, Gypsy & Travellers, people who are LGBTQ+, people with mental and physical disabilities and prisoners. After these sessions, 92% of people correctly identified the UK government drinking guidelines and 93% said they would now know where to get help if they were experiencing an alcohol problem.

⁵ Media advocacy is the process of disseminating information through the media, especially where the aim is to effect action, a change of policy or to alter the public's view of an issue.



INCREASING RESILIENCE

- 4 Resilience is key to dealing with adversity. By the end of the programme a total of 7,641 people had engaged with Drink Wise, Age Well resilience activities. This included 266 volunteers, 2,466 people who attended the structured groupwork resilience course 'Live Wise, Age Well', 302 individuals who were befriended by community engagers and 4,607 people who took part in the regular social activities. A further 16,385 contacts were made through one-off social and learning events.
- 5 An assessment of the Live Wise, Age Well course indicated its varied success in terms of developing resilience at individual level. The majority (70%) of participants entered and exited the programme with the same level of resilience. The programme appeared most beneficial for those who had low levels of individual resilience at entry. Of these, 48% reported normal levels of resilience by the end of the course. Among those who screened positive for risky drinking when they started the Live Wise, Age Well course, almost a quarter (24%) were not engaging in risky drinking by the end of the course.
- 6 Among people who attended social activities, 79% said their emotional health had improved, 80% said their relationships with others had improved and 82% said their sense of purpose had improved. Of those who drank alcohol, 38% reported that their alcohol use had reduced. In research interviews, some people in recovery from an alcohol problem told us they felt that the social activities helped them to develop an identity beyond being a person with an alcohol problem.
- 7 In research interviews with resilience activity participants, people reported increased feelings of hopefulness, optimism and (re)gaining a sense of purpose and/or a sense of control over their lives. Some also reported becoming fitter, losing weight or seeing an improvement in their blood pressure. Volunteering gave participants new skills and confidence and in some cases, helped a return to employment.
- 8 Group activities were not suitable for everyone. Some people who received one-to-one support were not comfortable with joining groups and others may have been unable to participate because they were housebound or had poor physical or mental health. It is notable that only a quarter of people who took part in resilience interventions were men. Some of the groups were self-sustaining but others ended with the programme.

SUPPORTING PEOPLE TO MAKE CHANGES TO THEIR ALCOHOL USE

- 9 A total of 6,575 people received screening and brief interventions face-to-face and 9,951 online. More than 60% said they had not been asked about their alcohol use by a health or social care worker or other professional in the last 12 months. Three-quarters of people who received screening and brief intervention had a score indicating hazardous or harmful alcohol use⁶. 43% said they intended to make changes to their drinking. Drink Wise, Age Well has recently launched an online alcohol health check tool specifically for older adults.
- 10 A total of 3,400 people received the alcohol intervention service for people with alcohol problems and 641 people received the webchat service. Among those who received the alcohol intervention service, 38% said it was the first time they had received alcohol treatment. One-third (33%) of people who received the Drink Wise, Age Well alcohol intervention service sought help from the service directly rather than being referred by a professional. 69% of people who received the webchat service said it was their first time accessing any support.
- 11 We compared alcohol treatment outcomes in people aged over 50 attending the Drink Wise, Age Well alcohol intervention service with outcomes for people aged 50 and over attending a mixed-age alcohol service. There was no statistically significant difference in alcohol consumption between the services but adults aged 50 and over were less likely to disengage from the Drink Wise, Age Well service.
- 12 In our research interviews, the Drink Wise, Age Well alcohol intervention service was generally regarded as preferable to mixed-age services because it offered a combination of approaches that met age-specific needs and focused on alcohol rather than alcohol and drugs. It also offered greater flexibility in terms of location, time and frequency of contact. Drink Wise, Age Well workers sometimes accompanied people to the local alcohol service with the aim of facilitating more clinical treatment or they provided advocacy and practical help to encourage engagement with these services. This was important since many people were unable or unwilling to attend local alcohol services due to mobility, lack of transport, physical and mental health problems and the stigma that they felt was associated with attending an alcohol service. Drink Wise, Age Well has recently implemented a national over 50's helpline to provide a route of contact for people who find it difficult to access alcohol treatment services.
- 13 Between assessment and discharge 74% of people attending the Drink Wise, Age Well alcohol intervention service had increased their wellbeing⁷, 45% had a reduction in anxiety⁸ and 44% had a reduction in depression⁹. There were statistically significant improvements in cognitive functioning after receiving the Drink Wise, Age Well alcohol intervention service but 30% of people still had some level of cognitive impairment when they left the service. Among people who reported poor physical health when they entered the alcohol intervention service, 55% reported improved health when they left the service.

⁶ Using age-adjusted AUDIT-C where a score of 3+ for women or 4+ for men aged over 55 indicates hazardous levels of alcohol use.

⁷ Using Shortened Warwick Edinburgh Mental Well-Being Scale (S-WEMWBS).

⁸ Using Patient Health Questionnaire (PHQ-9).

⁹ Using General Anxiety Disorder Scale (GAD-7).



REDUCING STIGMA AND DISCRIMINATION

14 Of those attending the alcohol intervention service who said they were unable to work when they entered the service, 33% were looking for work and 7% were working when they left the service. A total of 52% of people attending the alcohol intervention service had at least one alcohol-related GP, hospital inpatient, hospital outpatient, A&E visit, ambulance call or social work visit in the last 12 months. At six-month follow-up, this had fallen to 16%. There was a 34% reduction in the number of people reporting falls or accidents at 6 month follow-up.

15 More than 2,600 mutual aid¹⁰ (peer) support group sessions were facilitated for people with alcohol problems and 1,096 people attended them. A quarter of people who attended peer support groups didn't receive any other interventions from Drink Wise, Age Well. Among all those who attended peer support groups, 48% stopped drinking and 40% reduced their alcohol use. 85% said their emotional health improved, 79% said their relationships with others improved, 84% said their sense of

purpose improved, 76% said their ability to cope with changes in life improved and 94% said their motivation to address their alcohol problem improved. There is a significant amount of evidence from our research interviews that those attending support group sessions had an increased sense of mutuality and hope. The sessions were framed as 'friendly' and 'relaxed' and emphasised mutual interests and shared identities. People also liked the groups because they were small, more intimate and encouraged providing as well as receiving help.

16 Family support groups were established in some areas and appreciated by those who were able to attend, but were underused in other areas. Some family members received the 5-Step method intervention.¹¹ On average, there was a 50% reduction in "family burden" which is a measure of a combination of the negative impact of the problem, the family member's physical and psychological well-being, and styles of coping commonly associated with increased stress and strain. However, this was based on a relatively small number of people.

17 Drink Wise, Age Well's social media anti-stigma campaign 'Vintage Street' targeted the general public and reached more than a million people. The majority of people who saw the campaign said they were more likely to believe that society should treat older adults with alcohol problems with a tolerant attitude. Drink Wise, Age Well had conversations with 58,944 members of the public at public stalls. Training and awareness workshops were delivered to 28,428 professionals and older adults. Most people who attended the training said their knowledge increased. Some people said the training had challenged stereotypes they held of people with alcohol problems and people talked more openly about their own alcohol use as a result. Following training, professionals said they were more likely to have conversations with older adults about their drinking.

18 The most successful stigma-reduction activities that Drink Wise, Age Well delivered targeted people with alcohol problems. They challenged the negative beliefs and perceptions that individuals held about themselves through one-to-one support, helped them cope with experiences of stigma and discrimination through resilience activities, provided, a new sense of purpose and self-identity outside of their alcohol problem through social activities and volunteering and fostered mutual understanding and hope through peer support. However, there was no evidence that Drink Wise, Age Well reduced stigma among family members.

19 Drink Wise, Age Well's Calling Time: Addressing ageism and age discrimination in alcohol policy, practice and research report was referenced by the Scottish Government in their Rights, Respect and Recovery Drug and Alcohol Strategy to draw attention to increasing alcohol use in older adults. Based on the Calling Time report, the Drugs, Alcohol and Justice Cross-Party Parliamentary Group and All-Party Parliamentary Group on Alcohol Harm reminded alcohol services of their duty to address the needs of older adults, Alcohol Concern and Alcohol Research UK called for an end to age discrimination in alcohol treatment services and the Royal College of Psychiatrists drew attention to the scarcity of alcohol treatment services for older adults. Public Health England agreed to prevent residential alcohol services setting upper-age limits on its online directory of services. After a meeting between a local commissioner of alcohol services and Drink Wise, Age Well advocates with lived experience, organisations now have to describe how they will address the needs of older adults when bidding to provide a service.

¹⁰Mutual aid describes a defined relationship whereby the individual is both the donor and recipient of support based on shared life experiences. This term is used interchangeably with the term 'peer support groups' in this report.

¹¹The 5-step method was developed by Addiction and the Family International Network (AFINet): www.afinetwork.info. It is used for supporting families affected by a relative's substance use and is underpinned by the Stress-Strain-Coping-Support theoretical model.



RECOMMENDATIONS

INCREASING KNOWLEDGE, AWARENESS AND PROFILE OF THE ISSUE

RECOMMENDATION: Given the current financial climate, it is unlikely that alcohol services will be able to provide large public health information campaigns such as those successfully delivered by Drink Wise, Age Well. We therefore recommend that statutory public health agencies such as NHS Public Health Scotland and Public Health England design and implement a range of promotional campaigns to increase knowledge and awareness of the impact of drinking among older adults. These need to be targeted at specific audiences. For example: population based advertising is required to reach the general public to raise awareness of an issue or service; information and training is required for health and other professionals to help improve their knowledge and practice with older drinkers.

EVIDENCE: Drink Wise, Age Well was generally successful in reaching various sections of society and raising awareness of the programme and the impact of alcohol use among older adults. For example: more than 15 million people were potentially exposed to media messages about the Drink Wise, Age Well programme; 9,570 professionals had received Drink Wise, Age Well training representing over 150 organisations including the police, the fire and rescue service, Citizens Advice Bureau, the NHS, trade unions and care homes; 18,858 people aged over 50 attended workshops, workplace sessions or marginalised communities sessions. 90% of people who attended workplace training said they planned to make changes to their practice, 92% said they had improved understanding of age-specific issues and 97% reported that their knowledge of the subject had improved. 93% of people aged over 50 correctly identified the UK government drinking guidelines and 90% said they would know where to get help if they were experiencing an alcohol problem.

RECOMMENDATION: It is essential that time and resources are invested in engaging with marginalised groups on their terms. This includes identifying the most effective methods of advertising and contacting people. These methods should be local and culturally specific. Non-alcohol related activities may be the best way to improve engagement. For example: interest groups, sports and physical activity sessions.

EVIDENCE: Multiple sessions were delivered for specific groups including those with sensory loss, minority ethnic groups, carers, people living with dementia, people receiving elderly care, Gypsy & Travellers, people who are LGBTQ+, people with mental and physical disabilities and prisoners. Evidence from Drink Wise, Age Well's work with Black, Asian and other minority ethnic groups suggests it was successful in reaching out to people on their own terms e.g. language, culturally meaningful activities and working with existing health services serving these groups.

INCREASING RESILIENCE

RECOMMENDATION: Resilience-based interventions are recommended for older adults whether they consume alcohol or not. However, we recommend that greater resources are devoted to those who drink problematically, especially if their living environment supports an alcohol-oriented culture. It is recommended that adults over 50 with alcohol problems receive long-term resilience support that focuses on providing opportunities for engaging in alcohol-free activities and peer support networks.

EVIDENCE: Drink Wise, Age Well was successful in increasing resilience, in particular amongst those with low levels of resilience, and in doing so delivered support that helped to reduce alcohol related harm. The majority (70%) of participants in the resilience programme entered and exited with the same level of resilience. However, of those reporting a low level of resilience at entry, 48% reported normal levels of resilience by the end of the course. Almost a quarter (24%) of high-risk drinkers reduced their drinking significantly by the end of the resilience course. However, some people did not fully benefit from the course. For example, qualitative data indicated that men over 50 living on their own with a long-standing history of problem drinking found it most challenging to remain resilient particularly when influenced by external drinking networks.

RECOMMENDATION: Resilience based interventions should address individual, group and environmental resilience. Focus on one type of resilience, e.g. individual resilience, is not sufficient. This is particularly so for those who wish to develop more positive networks; those that require support from other services; or those who would benefit from meaningful activities such as volunteering.

EVIDENCE: From our qualitative research we found that Drink Wise, Age Well was successful in developing resilience at three levels among those who received support. The first was at individual level for example developing self-esteem and personal control over participants' lives. The second was relationships, for example building supportive networks that focussed on recovery. The third was environmental resilience, for instance referrals to other services and providing the opportunity to become a volunteer in Drink Wise, Age Well.

SUPPORTING PEOPLE TO MAKE CHANGES TO THEIR ALCOHOL USE

RECOMMENDATION: Services should adopt a proactive and assertive approach to engage older drinkers such as alcohol screening in public places and developing relationships with non-health organisations that are in contact with older adults in the community for example housing associations, social and welfare services.

EVIDENCE: Two thirds of those receiving advice had never been asked about their drinking before. 62% receiving the alcohol intervention service said it was the first time they had received alcohol treatment. Approximately 33% self-referred to Drink Wise, Age Well.

RECOMMENDATION: To improve engagement, it is recommended that services are age-focused, for example offer flexibility in terms of location, time and frequency of contact including, in some instances, home visits and accompanying participants to appointments. This is of particular importance to those who are unable or unwilling to attend due to mobility, lack of transport, physical and mental health problems, and stigma.

EVIDENCE: Of those receiving the Drink Wise, Age Well intensive alcohol service, 70% reduced their alcohol consumption by the end of treatment and more than half (57%) were drinking within the recommended weekly limits at that point. There were no discernible differences in these outcomes between Drink Wise, Age Well and adults over 50 receiving a mixed age alcohol service. However, those attending Drink Wise, Age Well were less likely to disengage from the service (3% Drink Wise, Age Well versus 10% mixed aged service). Our qualitative evidence suggests this may be linked to Drink Wise, Age Well staff engaging with older adults on their own terms, for example, adopting a non-judgemental attitude, being aware of generational expectations of older adults e.g. worried about asking for help and wary about self-disclosure.

RECOMMENDATION: Services should offer support to older drinkers that focus on outcomes other than alcohol consumption, including the proximal factors that may influence alcohol use for example, physical, social and mental wellbeing.

EVIDENCE: Approximately 74% of people attending the Drink Wise, Age Well alcohol intervention service improved their wellbeing by discharge. 45% reduced their anxiety and depression by discharge. There were also improvements in cognitive functioning, although 30% had cognitive impairment when leaving the service. Among people who reported poor physical health when they entered the alcohol intervention service, 55% reported improved health when leaving.

REDUCING STIGMA AND DISCRIMINATION

RECOMMENDATION: Stigma reducing interventions that focus on one-to-one support, building resilience and social connections and peer support are recommended for older adults with alcohol problems.

EVIDENCE: The most successful Drink Wise, Age Well stigma-reduction activities helped people with alcohol problems by challenging their negative beliefs and perceptions about themselves. They also helped people to cope with experiences of stigma and discrimination; provided them with a new sense of purpose and self-identity outside of their alcohol problem; and fostered mutual understanding and hope through peer support.

RECOMMENDATION: Establish and maintain a non-judgemental, non-stigmatising, open and inclusive service culture through positive leadership, annual appraisals and regular reflective practice. Integrate cultural aspects into staff training and supervision and consider addressing these in the organisational values and mission statement. New staff should have specific and dedicated training on these aspects and should shadow existing staff where possible. Peer work, including volunteering, should be encouraged to help develop a positive culture and improve engagement with drinkers aged over 50.

EVIDENCE: Evidence from across our evaluation emphasises the importance of a welcoming non-judgemental service culture when reaching and engaging older drinkers. Drink Wise, Age Well staff were mindful of the generational expectations of older adults which could limit their engagement with services (e.g. some older service participants can be more worried about asking for help and wary about self-disclosure). For those with an alcohol problem, emphasis was given to developing a therapeutic relationship with their case worker. Participants described this relationship as non-judgemental, compassionate and supportive; they said this encouraged them to engage further with the service and start making positive changes in their lives. Staff reported that in-depth knowledge, skills and confidence in discussing problem drinking with older adults was a precursor to engagement with Drink Wise, Age Well. Training and education about stigma was key to changing individualised and organisational stigma. The Drink Wise, Age Well volunteers valued their role in the organisation.

RESULTS

The contribution analysis found that Drink Wise, Age Well attempted to bring about change through four areas with some overlap:

INCREASING KNOWLEDGE, AWARENESS AND PROFILE OF THE ISSUE

INCREASING RESILIENCE

SUPPORTING PEOPLE TO MAKE CHANGES TO THEIR ALCOHOL USE

REDUCING STIGMA AND DISCRIMINATION

Each of these is considered individually in the remainder of this report.



INCREASING KNOWLEDGE, AWARENESS AND PROFILE OF THE ISSUE

PERFORMANCE NARRATIVE

The following section provides a narrative summary of Drink Wise, Age Well's 'performance' in terms of increasing knowledge and awareness about alcohol use in the over 50s. It is challenging at any time and in any context to achieve this goal, especially given the considerable stigma associated with alcohol problems and the common misconception that such problems are an issue mainly for younger people rather than older adults.

Regarding Drink Wise, Age Well's efforts to increase knowledge and awareness about alcohol issues among adults over 50, the programme produced and delivered a wide range of awareness raising activities, events and media campaigns as well as training courses for professionals. Overall, previous research indicates that these types of activities tend to be associated with an increase in knowledge about alcohol issues and help seeking. The data that were gathered appeared to indicate a link between service processes, service activity and events and increased awareness about alcohol issues among adults over 50 particularly when the Drink Wise, Age Well Programme had bedded down in communities. For example, referrals to Drink Wise, Age Well increased over the duration of the programme and referrals increased also following specific events such as the world record attempt to assemble the largest number of people to Jive in one location. Feedback forms and testimonies portrayed a similar picture - knowledge increased among service participants and training participants following Drink Wise, Age Well alcohol education sessions.

Drink Wise, Age Well used traditional media (i.e. radio, newspapers and leaflets) and there were many newspaper and radio adverts, articles and interviews, and a significant number of user-friendly leaflets were distributed. Much TV and radio coverage focused on informing the public about the Drink Wise, Age Well Programme as well as raising public awareness about drinking in older age. For example, Drink Wise, Age Well used Phil Collins' revelations about his 'battle' with alcohol in order to highlight Drink Wise, Age Well and alcohol problems among older adults. While evidence about the impact of media campaigns on changes in alcohol consumption is mixed, research suggests that there is an association between media campaigns and increased help-seeking. Drink Wise, Age Well had strong online presence. There was a significant number of Drink Wise, Age Well website visitors, many downloads of Drink Wise, Age Well guides, and an extensive reach via social media platforms such as Facebook and Twitter. The use of online and social media platforms to distribute Drink Wise, Age Well messages reflects public health practice whereby social media and online communication are used increasingly to advance health and health promotion due to their popularity among the public, including people who are over 50 years old.

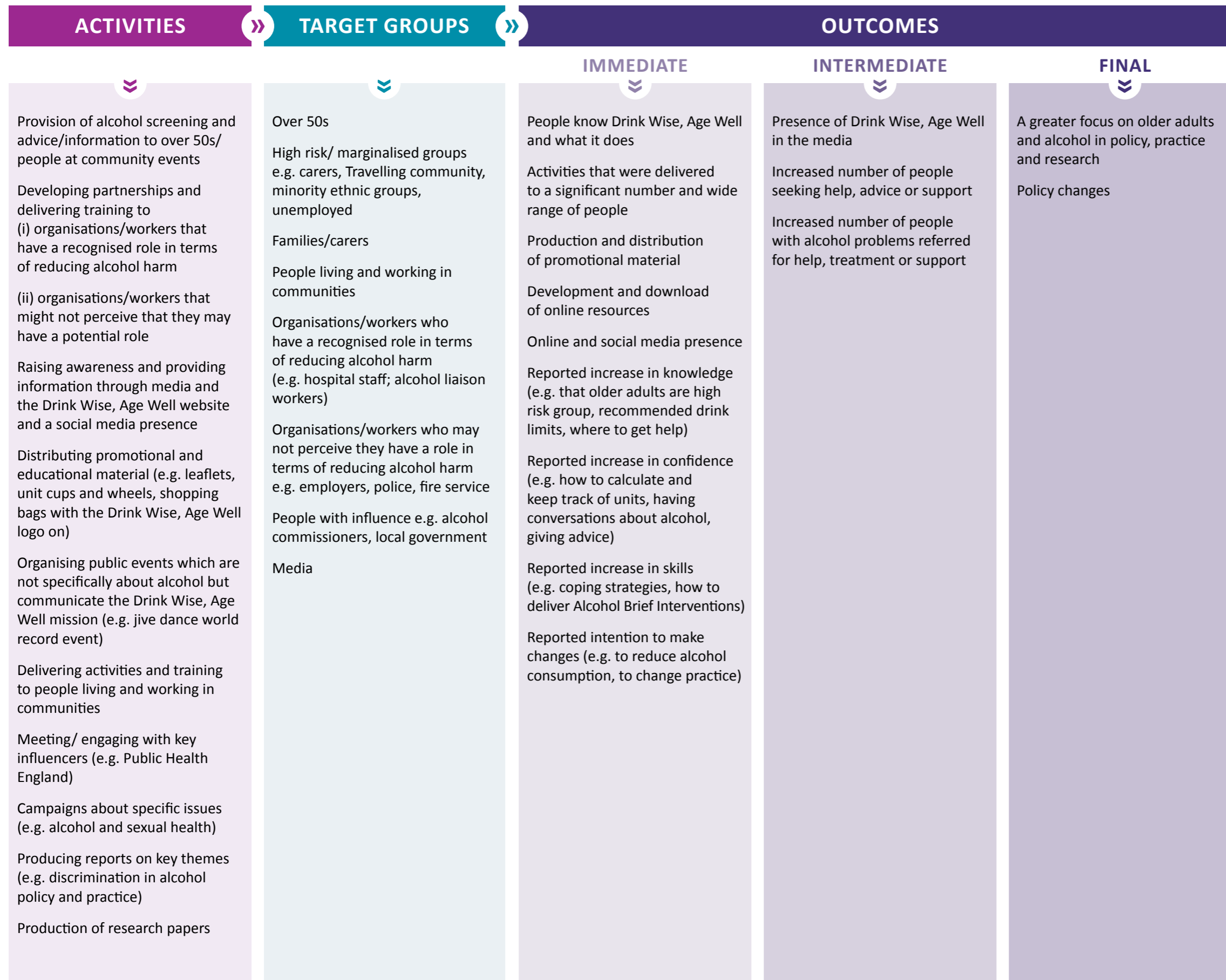
Drink Wise, Age Well training activities and courses about the over 50s and alcohol were popular and valued highly, particularly by health and social care professionals. Most participants of Drink Wise, Age Well training reported an increase in their knowledge about alcohol issues among over 50s, development of new skills and becoming more confident in broaching and discussing appropriately the topic of alcohol use with someone over 50. Research that indicates that older (compared to younger) adults tend to be less likely to be asked about their alcohol use and this professional hesitancy or reluctance affects their access to support and treatment. It seems reasonable to expect that professionals with increased knowledge, skills and confidence in discussing problem drinking with older adults would lead to a higher number of older adults becoming engaged appropriately with alcohol support and treatment services.

CONCLUSION

Awareness and knowledge about alcohol issues among adults over 50 appeared to increase during and following the implementation of the Drink Wise, Age Well programme. Awareness-raising activities comprised; media campaigns, a series of specific awareness-raising events, professional training, screening for hazardous or harmful drinking, educational interventions, and raising the profile of the issue of alcohol use among older adults in policy, practice and research.

The Drink Wise, Age Well programme had a focus on applying research to influence policy and practice around alcohol use in older adults. Learning from the Drink Wise, Age Well programme indicates the importance of lobbying at government level in order to ensure, for example, that public health efforts are inclusive and give due attention to all socio-demographic groups and all sections of the population.

LOGIC MODEL: INCREASING KNOWLEDGE



TESTING THE ASSUMPTIONS

We consulted research literature to explore whether the logic behind the key areas of activity was appropriate, including examining the basis of any theoretical assumptions made. The assumptions we considered were:

- Is there evidence that increasing knowledge and awareness among over 50s and in their communities will lead to changes in drinking behaviour and reductions in alcohol harm?
- Is there evidence that raising awareness of the issue will increase the extent to which alcohol use among older adults is on the public, political and practice development agendas?

Do media campaigns lead to a reduction in alcohol consumption?

Alcohol use is a contributory cause of more than 200 diseases, most notably alcohol dependence, liver cirrhosis and cancers.^[24] In addition, alcohol has a negative impact on families, communities, health and social care, the economy and the criminal justice sector.^[25-26] Alcohol use may have a significant and widespread impact on individuals and society and mass media may be an efficient approach to reaching populations about the dangers of alcohol consumption and reducing hazardous or harmful drinking.^[27-28] Population-based mass media campaigns about the dangers of excessive alcohol consumption have varied in length, content and delivery. Previously used methods or modes of dissemination for the delivery of mass media campaigns include newspaper articles, radio and television advertisements, magazines, posters and social media platforms.^[29] It is unclear which format or combination of features of a campaign produce the best outcome, and this question requires further investigation.^[30] However, previous research suggests that media campaigns were more effective when they were intense, long running and targeted to a specific population group.^[30] Mass media campaigns have the capacity to reach a large number of people at relatively low cost and this fact means that the 'audience' may choose whether or not to engage with, watch, read or listen to, the campaign without needing to actively seek out campaign messages.^[31] A large National Institute for Health Research (NIHR)-funded review identified 36 systematic reviews and individual studies that investigated the impact of mass media campaigns on six preventable risk factors. The umbrella review of reviews concluded that health media campaigns increased awareness about risks that were associated with harmful health behaviours and related health promoting services. The review noted that there were very few studies about social media campaigns.^[30]

Increasingly, social media and online modes are used to communicate public health and health promotion messages partly because they overcome physical access and geographical barriers.^[32] The public spend a significant amount of time using health websites and social media. We spend, on average, 14 minutes per site visit and 144 minutes per day on social media platforms.^[33-34] Several studies demonstrate the effectiveness of online modes and social media-related public health interventions in terms of behavioural changes.^[35-37] There appears to be some evidence that demonstrates positive changes in alcohol consumption following use of alcohol education websites. However, the effectiveness of social media in terms of changing alcohol behaviour has not been researched.^[38]

Generally, there appears to be less research about the impact of alcohol mass media campaigns compared to studies of mass media campaigns for other areas of health such as smoking^[30, 39] and evidence for the effectiveness of alcohol mass media campaigns is unclear. For example, a two-year mass media campaign (including TV, newspaper, radio, posters and leaflets) about the dangers of drink driving reported a large reduction in the number of drivers with illegal blood alcohol concentrations.^[40] The number of fatal crashes during the evaluation time-period did not decrease significantly though, perhaps, the number of crashes may have continued to incline had there not been a campaign. A recent systematic review of 24 studies concluded that there was a weak or no association between a reduction in alcohol consumption and exposure to specific alcohol media campaigns.^[41] It is important to note that none of the interventions in this review included older adults thereby indicating again that, often, alcohol use by older adults does not appear to receive appropriate attention^[42] though, depending on their reach, alcohol campaigns raise awareness potentially across all age groups.

Do care professionals need training on alcohol use issues in older adults?

Wadd & Papadopoulos^[43] reported that, often, health professionals do not explore alcohol use in sufficient depth with older adults and alcohol problems may be undetected or undiagnosed. Non-specific illnesses such as insomnia and gastrointestinal issues or conditions such as depression and dementia may obscure alcohol use issues in older adults. Health professionals may recognise and diagnose a medical problem but not connect it to alcohol use. Furthermore, there is a common misconception that alcohol problems are problems that mainly young people encounter. There may be reluctance amongst health professionals to assess alcohol use in older adults.^[44] In addition, there may be a lack of awareness among health professionals about the benefits of alcohol treatment in later life and, perhaps, a clouded view that alcohol was 'all that an older person had left in their life'.^[45-46]

This relative lack of knowledge about the health effects of alcohol for older adults and these attitudes towards older adult's drinking might explain, partly, the under assessment of alcohol use by older adults. Collectively, these findings seem to point to the need to deliver additional training to health and social care professionals in order to increase their awareness about alcohol use issues in older adults and the potential benefits of referral to specialist treatment services and support. Older adults tend to engage increasingly with health and social care professionals as they age. Therefore, each care professional-older adult contact presents an opportunity to consider whether to screen for alcohol use issues and to provide appropriate alcohol interventions.

Does increased alcohol knowledge lead to a reduction in alcohol consumption?

There is conflicting evidence about the effectiveness of educational interventions and measures in terms of increasing knowledge and subsequently reducing alcohol consumption. Few studies focus specifically on older adults. A large cluster randomised controlled trial (n=1186) found that a multi-component alcohol educational intervention for older adults which included screening, health professional advice and educational materials compared with standard care, reduced hazardous and harmful drinking among older adults and this positive effect was sustained over 12 months. There was also a self-reported increase in alcohol-related conversations between study participants and their physicians.^[47] Single component and, in particular, education-only (or knowledge-based) interventions do not appear to recognise and consider the complex nature of drinking behaviour and exert no or limited impact.^[48]

Education-based interventions combined with alcohol screening may have a greater impact on alcohol use. There is considerable evidence, spanning several years, supporting the use of screening combined with brief advice. Recent findings from a large UK multicentre, multi-setting (including primary care) trial of screening and brief advice pointed to the potential benefit of universal screening.^[49] Furthermore, the provision of alcohol screening and brief advice at 'teachable moments' or times of crisis (e.g. presentation of drinkers at hospital A&E Departments) may reach people with previously unrecognised alcohol use disorders who may be more receptive to educational messages and facilitate access to specialist alcohol treatment.^[50]

EVIDENCE IN RELATION TO THE LOGIC MODEL

IMMEDIATE OUTCOMES	
OUTCOME	EVIDENCE SUMMARY
People know Drink Wise, Age Well and what it does.	<p>Early in the project, there was a mixed response regarding whether or not people knew about Drink Wise, Age Well and its aims and activities. The views of Drink Wise, Age Well management suggested that there was awareness about the 'brand' and ethos of Drink Wise, Age Well:</p> <p>“ I think one of the best things for us has been everybody... well getting our brand out there actually and when I say brand obviously I mean the Drink Wise, Age Well brand but I mean more importantly getting the alcohol and ageing message on the agenda for a lot of people. Drink Wise, Age Well manager</p> <p>However, the views of participants at this time suggested that more work needed to be undertaken to improve awareness about Drink Wise, Age Well and its message:</p> <p>“ I would have never ever, it was only luck. It was in a tiny column and in the local paper. I don't think many folk would really, well maybe they do but I think it should be advertised more definitely. I don't think it's given the credit it should be given. 52 year old, female, Drink Wise, Age Well participant</p> <p>Similar to participants' views, stakeholders reported that more work was needed to improve awareness about Drink Wise, Age Well and its message:</p> <p>“ I don't know how much that other organisations or other services in this area know about Drink Wise, Age Well. I could be wrong but I've never really... I've never seen you guys having a presence here apart from the kind of the work that I've done with them the direct referrals and encouraging them to come and speak to the groups. Drink Wise, Age Well stakeholder</p> <p>It is important to highlight that the above quotes came from an earlier Drink Wise, Age Well report. There were significant efforts to promote the programme as the project progressed. Drink Wise, Age Well undertook significant local promotion of the programme using a range of different platforms. Billboards, local newspaper articles and radio campaigns were used in Northern Ireland; Sheffield conducted a large leaflet drop featuring the 'Dry Days Campaign' and posted advertisements on buses; Glasgow placed advertisements and featured articles in the Evening Times and Herald, and screened advertisements in hospitals. Awareness of the programme increased over time:</p> <p>“ I have just noticed recently just dealing with [expressions of interest] and referrals coming in there has been, and this is a new thing for me, direct referrals from GPs. Not a lot, about half a dozen in the last couple of weeks, but somethings connected. Drink Wise, Age Well locality manager</p> <p>“ I have also noticed a big increase in self-referrals and in my opinion this was due to the Programme being advertised on local news stations, one of the questions at the end of the referral process is to ask how the client heard about the service, I noticed a huge rise in clients saying it was from the local radio adverts, therefore I feel as though this was a successful way of advertising. Drink Wise, Age Well locality manager</p>

IMMEDIATE OUTCOMES	
OUTCOME	EVIDENCE SUMMARY
Activities were delivered to a significant number, and wide range, of people	<p>Drink Wise, Age Well delivered awareness raising events to the public. Examples of these activities included targeted alcohol-specific events and alcohol events that were open to everyone. An example of an open alcohol awareness event was the 'Jive' - a world record attempt in Northern Ireland to get the biggest number of people jiving at the one time in the one location. It was thought that this type of event would interest the target population, 'over 50s', and it was promoted through mass media e.g. posters, leaflets, social media, radio and television advertisements. Free jive classes were offered in the local area to over 50's which incorporated messages about safe alcohol consumption. The event took place in July 2017; 1316 attended the Jive event in various ways (e.g. via the public information stands); 409 were under 50 while the majority (n=907) were over 50; 158 people jived in Ebrington Square. The Northern Ireland Drink Wise, Age Well team deemed that the event raised awareness about Drink Wise, Age Well services (even though the world record was not broken). For example, referrals in the quarter following the event increased by 39%. Furthermore, evaluation data indicated that 94% of participants reported that their attendance at the event increased their knowledge of Drink Wise, Age Well. Every participant received a goodie bag on the day with 'freebies', a leaflet about the Drink Wise, Age Well service and a leaflet designed specifically to link Drink Wise, Age Well and Jive and the topic of stigma.</p> <p>An example of a Drink Wise, Age Well alcohol-specific event was an 'alcohol advice and information 'pop-up shop'. These shops were an extension of the one-off advice and information stalls that Drink Wise, Age Well offered at community events and festivals. Drink Wise, Age Well staff were present and visible in a dedicated public area over a sustained period of time in a way that gave the general public, opportunities to build up a level of confidence that would lead them to approach a stand for advice and information. For example, advice about alcohol and health was provided in Crystal Peaks Shopping Centre Sheffield to 1827 people (89% were aged 50+) for 6 weeks (May 2017-June 2017).</p> <p>In Glasgow, the team developed a campaign 'Swap Your Swally' which engaged 181 members from the local community. The campaign was promoted extensively on TV and social media. The team also collaborated with the Transport Police and a local alcohol charity to promote the campaign at a transport hub. The campaign involved inviting members of the local community to watch a world cup match on a big screen, try a non-alcoholic mocktail (as an alternative to alcohol) and increase their knowledge about, and/or challenge their attitudes to, alcohol. The event was extended (beyond a one-off session) to include an intensive month-long campaign in community and workplaces.</p>

IMMEDIATE OUTCOMES

OUTCOME	EVIDENCE SUMMARY
	<p>Drink Wise, Age Well increased accessibility via 'Live Wise, Age Well' sessions that were presented in workplaces and enabled the programme to reach individuals with resilience-related messages (and alcohol education) who were unable to access Drink Wise, Age Well courses due to work commitments (69% of those attending were women, 50% were > 65 years old and 4% self-identified as BAME or 'other' ethnic background). Drink Wise, Age Well Northern Ireland partnered up with 'Business in the Community' to ensure employed people could avail of Drink Wise, Age Well workshops, programmes and sessions. Furthermore, inclusive alcohol workshops were delivered to various groups: mental health organisations, elderly care, dementia, physical disabilities (auditory and visual impairment, sensory loss), women, carers, LGBTQ+, prisoners, Polish community, Black, Asian and other minority ethnic support services including Travellers and Roma community, Chinese community and Zimbabweans.</p> <p>An example of a media campaign that Drink Wise, Age Well Northern Ireland tailored and delivered was: "Sexual health, alcohol and the over 50s campaign". This campaign took place after consultation with the local Health and Social Care Trust Health Improvement Team (HIT) in order to gain a better understanding about local statistics regarding the sexual health of people over 50 years old. According to the HIT, this population were not presenting to sexual health services due to a lack of awareness about sexual health. The campaign identified the need to help over 50s acknowledge their sexual health, the increased risk to sexual health in relation to alcohol-related harm, the impact on decision-making whilst 'under the influence', internet dating and online safety and lifestyle health generally. Appropriate health promoting materials about each topic were developed and formed into a social media campaign. In particular, the campaign highlighted key signs and symptoms, local sexual health clinics, the link between alcohol and sexual health, internet dating and keeping safe.</p>
<p>Production and distribution of promotional leaflets</p>	<p>Drink Wise, Age Well distributed a significant amount of literature in the form of leaflets. A total of 60,000 leaflets or interactive materials were distributed at public information stands and advice was given in response to 25,000 enquiries. The significant volume of promotional material is likely to have contributed to an increased awareness about alcohol use issues in over 50s and also increased awareness about the Drink Wise, Age Well service.</p>
<p>Development, and download, of online resources</p>	<p>There was ongoing development of online resources, factsheets and guides for the over 50's (see Resources section of the Drink Wise, Age Well website - https://www.drinkwiseagewell.org.uk/). Throughout the duration of the Drink Wise, Age Well Programme there was considerable website traffic. The resources section features seven downloadable factsheets including factsheets on Alcohol and Dementia, Food and Mood, Alcohol and Medications, Alcohol and Diabetes, Mindfulness, Worry and Problem Solving and Sleep. Unfortunately, the number of times that each factsheet was downloaded is unclear. The Drink Wise, Age Well website also contains other guides including: The Family and Friends guide to dealing with someone misusing alcohol, A workplace guide for alcohol misuse in the workplace, A guide to making healthier choices in older adulthood, and What is a unit? There appeared to be a high level of use of factsheets. For example, 273 page views and 202 unique views were recorded for the workplace guide (and perhaps may suggest that employers and occupational health professionals valued Drink Wise, Age Well materials).</p>

IMMEDIATE OUTCOMES

OUTCOME	EVIDENCE SUMMARY
<p>Online and social media presence</p>	<p>Drink Wise, Age Well online and social media presence increased over time. Final website stats indicated that there were 155,813 sessions, 121,476 individual users and 2.28 pages viewed per session. The Drink Checker on the Drink Wise, Age Well website was used often - 10864 alcohol brief interventions started and 9951 completed. However, data analysis suggested that use of the website was low compared to other health information websites - the average length of time spent on the Drink Wise, Age Well website was 1 minute 46 secs compared to 14 minutes on other health websites (see literature review). It is important to note that the Drink Wise, Age Well website had to be exited in order to complete the Drink Checker and this feature may have affected the calculation of website time. Drink Wise, Age Well had significant presence on social media platforms Facebook and Twitter. A total of 834,000 Twitter impressions were recorded (defined as the number of times a tweet shows up on someone's time line) and 212,643 Facebook impressions (defined as the number of times a post from a page/ account is displayed). Data on Facebook and Twitter impressions was unavailable for the earlier part of the project.</p> <p>Webchat (launched in July 2018) was an important aspect of Drink Wise, Age Well's online presence: there were 641 webchats, average duration in a webchat was 16 minutes and 77% of webchat participants had never accessed support in person.</p>
<p>Increase in knowledge (about alcohol and the Drink Wise, Age Well service)</p>	<p>9,570 professionals received Drink Wise, Age Well training. 90% of people who attended the training said they planned to make changes to their practice – mostly that they would have more conversations with over 50's about alcohol. 18,858 members of the public attended alcohol education sessions or workshops provided by Drink Wise, Age Well and after these sessions or workshops, 92% could correctly identify the current UK guidelines relating to alcohol consumption (68% could not identify UK government drinking guidelines prior to the session). Increased knowledge about alcohol and older age was evident from feedback comments by participants of Drink Wise, Age Well training events/awareness sessions:</p>
	<p>“ But what I liked is I think we are all bombarded with the units, but they don't mean anything to anybody. You see it all the time and you don't actually take it in how actually very little it is that you should be having on a weekly or daily basis. When [Drink Wise, Age Well worker] came and she physically puts it in front of you, has a glass and says pour what you think is a normal measure of wine. It was those kinds of things that really actually physically seeing that.</p> <p>“ Even at the time that they were telling you how long it took to get out of the system. A unit takes an hour. A lot of people weren't aware of that and they were then quite shocked at how slowly it takes to go out of your system when they're going to the work the next day or driving their kids to school, that kind of thing.</p> <p>Following 'The Jive' promotional campaign, most participants (94%) reported an increased awareness about the work of Drink Wise, Age Well. Approximately, 9% of service participants reported that they heard about the service through a leaflet or poster, 3% from a newspaper and 3% from the website.</p>

IMMEDIATE OUTCOMES

OUTCOME	EVIDENCE SUMMARY
<p>Reported increase in confidence e.g. how to calculate and keep track of units, having conversations about alcohol, giving advice</p>	<p>The majority of professionals reported that their confidence in relation to working with over 50s and their alcohol issues increased following attendance at training sessions. Feedback from alcohol brief interventions appeared to indicate a positive impact on drinking habits:</p> <p>“ I engaged with that [alcohol brief intervention provider speaking to me about my drinking habits] for a while, believing that I don’t drink that much, and probably finished the conversation with realising that I drink a bit more than what I probably should drink. [...] I’ve made some slight changes. I was drinking a pint and then driving. I hadn’t realised that a pint of beer was well over the [Scottish] limit [...] So I’m not actually drinking now if I go out and play golf. I’ll have a pint of soda water and lime, or something. Alcohol brief intervention recipient</p> <p>Some participants reported a better understanding about units of alcohol:</p> <p>“ I think it (how much alcohol we drink) is something that we think we know about that we don’t really fully understand. So I think for me it was quite nice to just have a chat about it, to speak to them (Drink Wise, Age Well alcohol brief intervention providers), to realise what a glass of wine really means, what the different percentages in wine actually mean, and how that relates to units and how that relates to calories as well. [...] I think if you’re made aware of it you actually start to think about it as you’re having a glass of wine. For example, it really amazed me that a glass of wine has more units in it than, say, a Bacardi, things like that. I wouldn’t have actually known that. I would have at least thought it had more calories, but not units of alcohol Alcohol brief intervention participant</p> <p>Most ‘Jive’ participants (94%) reported that they were more confident after the event about accessing Drink Wise, Age Well support.</p>

<p>Reported increase in skills</p>	<p>The one-day course and the enhanced alcohol awareness course appeared to improve the skills of professionals that attended e.g. 90% who attended the one day course planned to make changes to their practice, 93% reported improved understanding about age-specific issues and 96% reported an improved level of knowledge about the subject. Qualitative data suggested that people also experienced an increase in skills that helped them to cope with their hazardous or harmful use of alcohol:</p> <p>“ [name of worker] was brilliant, she taught me so much about how to cope with it when the craving came on, I can now cope with it as I know how. 69 year male Drink Wise, Age Well recipient</p> <p>“ It was a well-run, well-explained course and I feel it will help me in my practice and my personal life.... Practitioner</p>
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IMMEDIATE OUTCOMES

OUTCOME	EVIDENCE SUMMARY
<p>Reported intention to make changes</p>	<p>A total of 656 professionals left free response comments that tended to revolve around feeling more confident about broaching the topic of alcohol with older adults, being more proactive and asking permission to discuss alcohol. Here are some examples of typical comments:</p> <p>“ My practice will inevitably change/improve as a result of this course because I now feel more confident and informed about engaging with older people and speaking to others (professionals etc.) about alcohol and ageing. Training Recipient 1</p> <p>“ To be more pro-active when having conversations with residents, confident in approaching the subject. Training Recipient 2</p> <p>“ Ask permission before discussing alcohol consumption. Would it be ok if we discussed how alcohol might be affecting your health? Training Recipient 3</p>

INTERMEDIATE OUTCOMES

OUTCOME	EVIDENCE SUMMARY
<p>Presence of Drink Wise, Age Well in the media</p>	<p>The launch of the Drink Wise, Age Well website and the first report in January 2016 received significant media coverage including BBC Breakfast, radio interviews on all regional BBC stations, articles in the Sunday Times, Daily Express, Belfast Telegraph, Scotsman and a number of other regional newspapers.</p> <p>Generally, Drink Wise, Age Well had a noticeable media presence via radio interviews, newspaper articles, social media adverts and so on. An interview with the Drink Wise, Age Well Programme Manager about alcohol and the over 50s featured on more than 40 BBC radio stations in November 2017. A story about singer, Phil Collins, opening up about his alcohol use and its harmful effect, led to an interview with Drink Wise, Age Well staff, which featured a link to the website and links to 11 other online articles. This publicity appeared to boost website traffic, with 14,198 page views that month compared to an average of 7000 views per month. A follow-up article on the same topic appeared in the Scottish Daily Mail. There was good coverage by media at a local level. For example, in Year 2 of Drink Wise, Age Well, there was a 2-page spread in the Sheffield Star about alcohol among over 50s and Drink Wise, Age Well. In Wales, the Locality Manager promoted Drink Wise, Age Well on an ITV Wales news bulletin and in Devon Drink Wise, Age Well appeared on BBC Spotlight. More than 40 BBC radio stations featured interviews promoting the ‘Calling Time Report’. The report also featured in major newspapers including the Sunday Times, Daily Mail, and Herald as well as in local regional papers. The Drink Wise, Age Well website received 10,109 page views that month (May/June 2019) compared to an average of 7,000 per month.</p>

INTERMEDIATE OUTCOMES

OUTCOME	EVIDENCE SUMMARY
<p>Increased number of people seeking help, advice or support</p>	<p>A total of 6,575 Alcohol Brief Interventions were carried out using the FAST and AUDIT-C screening tools. There were over 13,500 contacts to the service; 56% were self-referrals and 36% were professional referrals which indicated that a significant number of people reached out directly to Drink Wise, Age Well for help or via a referral from a care professional. Expressions of interest reflect only part of Drink Wise, Age Well activity, as much of the Drink Wise, Age Well prevention work in local communities did not require referral.</p>
<p>Increased number of people with alcohol problems referred for help, treatment or support</p>	<p>The number of referrals to specific elements of the Drink Wise, Age Well programme increased throughout the duration of the programme. For example, alcohol intervention service referrals increased each year aside from Year 5 when there was a slight decrease because Drink Wise, Age Well stopped accepting referrals to the alcohol intervention service several months before the end of Drink Wise, Age Well funding period (Year 1, 627 increasing in Year 2 to 1053, 1331 in Year 3, 1577 in Year 4 and 1252 in Year 5).</p> <p>Referrals from the statutory sector were slow during the early period after the initiation of the Drink Wise, Age Well Programme: "I thought we'd have probably have got more from GPs. It should be an easy phone call, aye, to make." The pattern of referrals increased over time including referrals from GPs. This pattern highlights that new services like Drink Wise, Age Well take time to embed in existing local service networks.</p>

“When I think about referrals throughout my time with the project I definitely believe we saw a steady flow and increase of referrals into the project. From looking at monthly and yearly reporting figures, we can see the growth in numbers clearly and the response rate to positive engagement was also really encouraging. The links and referral pathways we developed strengthened with each referral made and individuals showing belief in the work that we do. From feedback received the importance and name of the service grew, which I also believed added to the increase we saw in family and self-referrals. The positive feedback lowered fears and anxieties for individuals and encouraged them to seek out help for themselves. There was a steady flow of referrals across the whole geographical area, and especially for the new multi-disciplinary teams that sat within GP surgeries in the [name removed] and [name removed] area we became a key service for their referral pathways. Drink Wise, Age Well locality manager

“I do believe referrals have steadily increased over time and this is due to the dedication of the Prevention and Campaigning staff who successfully promoted the Programme and also the general public word of mouth and professionals gaining confidence in the service over time. Drink Wise, Age Well staff member

FINAL OUTCOMES

OUTCOME	EVIDENCE SUMMARY
<p>An increased focus on alcohol use among older adults in alcohol policy, practice and research.</p>	<p>The work by Drink Wise, Age Well was cited by:</p> <ul style="list-style-type: none"> • The Scottish Government to support a case for older adults to be treated as a 'priority group' in terms of receiving services designed to reduce alcohol harm • The UK Drugs, Alcohol and Justice Cross-Party Parliamentary Group and the All-Party Parliamentary Group on Alcohol Harm to advocate that alcohol services should address the needs of older adults • The Royal College of Psychiatrists to highlight the scarcity of substance misuse services for older adults • Alcohol Change UK to call for an end to age discrimination in alcohol services <p>Drink Wise, Age Well in Wales forged strong relationship with the Welsh Government Substance Misuse Team and additional funding was awarded to continue some elements of the Drink Wise, Age Well programme and to support 'Legacy Roadshows'. In addition, the Charter for Change was included as a specific action in the Welsh Government's new Substance Misuse Delivery Plan due, in part, to the positive relationship between Drink Wise, Age Well and the Welsh Government.</p> <p>An Alcohol Services Commissioner expressed support for an age-appropriate response to the service needs of older adults and for the sustainability of Drink Wise, Age Well-related projects (outlined in a letter from the commissioner following a meeting with the Drink Wise, Age Well locality manager and the Charter for Change Group):</p>

“We will be specifying when we go out to tender that bidders have an age specific response to needs of older people using alcohol, including flexible delivery and community based work as far as resources will allow. We will also do our best to support the sustainability of the projects started by Drink Wise, Age Well wherever we can. This will include making our offer on outreach more comprehensive.

Influencing by Drink Wise, Age Well has led to four parliamentary questions being submitted and answered by the UK Government, drawing attention of the Government to the issue. Furthermore, partner organisations of Drink Wise, Age Well represented the issues of alcohol and older adults to local and regional government bodies. For example, the partner organisation, Brandywell and Bogside Health Forum (BBHF), presented these issues to the Western Independent Sector Forum (WISF) that linked directly to the Northern Ireland Committee for Health, Social Services and Public Safety. In turn, BBHF's membership of, and presentation of these issues to, the WISF influenced strategic service planning. Drink Wise, Age Well Northern Ireland discussed alcohol harm among older adults with a cross-party group of Westminster MPs, and convened an annual high-level impact meeting in Stormont with key political representatives and lead agency members including Members of the legislative assembly (MLAs) Head of Fire service, Police and the Public Health agency. A wide range of MPs and stakeholders across all localities expressed support for the core mission of the Charter for Change.

A planned series of papers and reports will disseminate learning from Drink Wise, Age Well and aim to influence policy and practice. The evaluation team have already published academic papers and had other papers accepted for publication, and guides for practitioners have been produced. Lobbying work by Drink Wise, Age Well influenced Public Health England to remove the upper age limit from their eligibility criteria from the directory for alcohol rehab services (though individual rehab services may decide to retain age as an eligibility criterion). Drink Wise, Age Well successfully lobbied the Department of Health in Northern Ireland to include people aged over 75 in the Northern Ireland Adult Drinking Patterns Survey.

INCREASING RESILIENCE PERFORMANCE NARRATIVE

Resilience is the ability to adapt positively to stressful life circumstances. Being resilient is especially important in older age which can be a challenging time of life, and includes changes such as retirement, bereavement or reduced physical mobility. Excessive alcohol use may be a response to these, however, this may result in poorer physical and mental health. At the same time, older adults face barriers to using mainstream alcohol services and problem drinking frequently goes unnoticed. This is why Drink Wise, Age Well was designed specifically as an alcohol service for older adults, aged 50 and over.

One aim of Drink Wise, Age Well was to help older adults build resilience and prevent or reduce hazardous or harmful alcohol use. There are three domains of resilience: individual (personal resilience), social (having empowering relationships with others), and environmental (having access to adequate resources, including care and material resources). Drink Wise, Age Well aimed to develop resilience across these domains through a programme of individual and group support. Older adults with an alcohol problem (or their family members) were offered one-to-one support to address their issues and were encouraged to join a peer support group and other social groups.

Social groups were aimed at both drinkers and non-drinkers and included social activities and events such as cooking, painting, yoga, learning and development workshops or organised day trips. Along with these, a six-week resilience group work course, Live Wise, Age Well, was delivered in a variety of settings (e.g. workplaces, community settings). This taught course focused on developing resilience in older adults through stress management, coping skills, relaxation techniques and mindfulness. It also covered areas of well-being such as diet, sleep, exercise and alcohol use.

WE ASKED TWO QUESTIONS:

- 1 How did Drink Wise, Age Well help develop resilience?
- 2 To what extent did these resilience-based activities help in the short and long term?

What did participants receive and how did this help in the short term?

Drink Wise, Age Well aimed at building resilience to hazardous or harmful alcohol use in older adults across the board, by providing intensive individualised sessions or group work. This was reflected in the broad scope of the project work streams and activities. The one-to-one alcohol intervention service and peer support groups were targeted at older adults with an alcohol problem and their families in particular. Other activities, such as social activities and the Live Wise, Age Well programme were aimed at older adults in the communities, regardless of their levels of alcohol consumption. Resilience-building activities, aimed at preventing or reducing alcohol use in older adults, ran throughout the Drink Wise, Age Well programme. The starting point differed for those engaged in hazardous or harmful alcohol use and in recovery, and for those who were non-drinkers or drinking at low levels.

For programme participants with an alcohol problem, the first step was developing a therapeutic relationship with their keyworker.

Programme participants described this relationship as non-judgemental, compassionate and supportive, they said this encouraged them to engage further with the service and start making positive changes in their lives.

Drink Wise, Age Well staff provided both emotional and practical support to do so. First, they helped programme participants find or identify the motivation to change their drinking habits and develop relevant coping strategies. In their one-to-one work, Drink Wise, Age Well staff provided on-going guidance, encouragement and emotional support. Their approach was based on building a relationship of trust which empowered programme participants to take ownership of the solution. As a result, they felt empowered to make decisions and take charge of their lives – a feeling many of them had previously lost due to their excessive drinking.



Drink Wise, Age Well staff also provided high levels of practical support, often working alongside other agencies to address particular needs. In some instances, they accompanied programme participants to medical and other appointments or to exercise/activity classes. Others were encouraged to enrol in rehabilitation facilities or helped to access social housing. Programme participants in the alcohol intervention service thought the level of practical support provided by Drink Wise, Age Well staff and the amount of time they devoted to an individual was unique to this service. Programme participants and staff thought this was very helpful, especially for people with alcohol issues who could not access mainstream services (e.g. due to mobility or mental health issues) and those who had previously engaged unsuccessfully with other services. Programme participants in recovery said Drink Wise, Age Well helped them (re)gain control of their life which greatly improved their well-being.

Having close connections to others and strong support networks is another pillar of resilience. Therefore, programme participants who were drinking problematically were also encouraged to join peer support groups. These were small groups which met weekly and focused on alcohol-related issues. At the meetings participants could share their stories and learn about their peers' journeys through problem alcohol use and recovery. Those who attended the peer support groups found sharing experiences with people who understood them very powerful. Such meetings helped them understand their own recovery journey and further motivated them to control their drinking. Moreover, many close friendships were forged within the peer support groups providing those in recovery with a new support network. Programme participants with alcohol problems were also encouraged to take part in other Drink Wise, Age Well social activities which were not focused on alcohol recovery in particular. These group activities were not suitable for everyone. Some programme participants receiving one-to-one support were not comfortable with joining peer support groups or taking part in other social activities. In such cases, the relationship between the Drink Wise, Age Well case worker and the programme participant was the key to developing resilience and making changes in their life.

A broader array of Drink Wise, Age Well resilience stream activities were aimed at older adults in local communities regardless of their drinking levels. They included various social groups, activities and events as well as Live Wise, Age Well, a structured group intervention programme. The objective of resilience activities was to build resilience through strengthening links with others along learning coping skills, so that participants would not turn to alcohol to cope when faced with challenging life changes. Participants of social groups, events and activities said that being able to socialise and develop wider support networks proved very important for building their resilience. The resilience activities helped them make new friends, particularly those service participants who were previously very isolated and largely home bound. Participants across the board very much appreciated having opportunities to join organised walks, go on day trips, and take part in various educational classes.

Some participants who were in recovery especially valued the lack of focus on alcohol within these social activities. Such activities enabled them to simply spend time and mix with others without necessarily identifying as a problematic drinker. This and being able to broaden their personal networks outside the alcohol recovery peer support group was seen as helpful in making and sustaining positive change. Taking part in social activities also provided many participants with a sense of purpose and increased their confidence. Activities which involved developing new interests or (re-) learning skills, including the Live Wise, Age Well course, brought joy and a sense of achievement which boosted participants' confidence. In a few cases, becoming involved in Drink Wise, Age Well activities sparked such interest and passion that it ultimately led participants to volunteering work in and outside the project.



Longer-term outcomes

Drink Wise, Age Well helped programme participants build resilience and resulted in a number of positive outcomes. For some, it had 'changed their life'. Above all, it improved most programme participants' mental health and wellbeing. Across the board, people reported increased feelings of hopefulness, optimism, and (re)gaining a sense of purpose and/or a sense of control over their lives. Those who regularly took part in group activities embarked on a positive lifestyle change by becoming more active and doing enjoyable activities, spending more time with other people, and making new friends and developing networks of support. Increased activity also had a positive impact on participants' physical health: some reported becoming fitter, losing weight, or seeing an improvement in their blood pressure. Moreover, for participants who became involved in volunteering this was often the beginning of a new chapter in their lives. Volunteering gave them new skills and confidence, and in a few instances ultimately supported their return to the labour market. Most Drink Wise, Age Well programme participants reduced their alcohol consumption as a result of the intervention, including those who were drinking at low levels overall. For instance, over one-third of people who had taken part in social activities (which were not focused on alcohol issues) reported a decrease in their drinking levels.

This demonstrates that short-term non-alcohol focused resilience building activities can help participants reduce their alcohol use, even if they have been drinking at low levels. Furthermore, the majority of participants who had an alcohol problem successfully reduced their alcohol consumption, both in terms of cutting down the amount of alcohol they drank and how often they drank. These participants felt positive about the changes they had made, appreciated how much they had improved their lives and were keen to continue on the path to recovery. While some people in recovery went through a relapse during the intervention, those who returned to the programme continued to pursue the goal of recovery. Nevertheless, this group of participants, and especially single men who were living on their own and had a long-standing history of alcohol problems, found it most challenging to remain resilient longer-term. Many programme participants recovering from alcohol problems felt they needed sustained external support to maintain lower drinking levels. Therefore, it is difficult to predict whether they would be able to remain resilient in the future without such support.



CONCLUSION

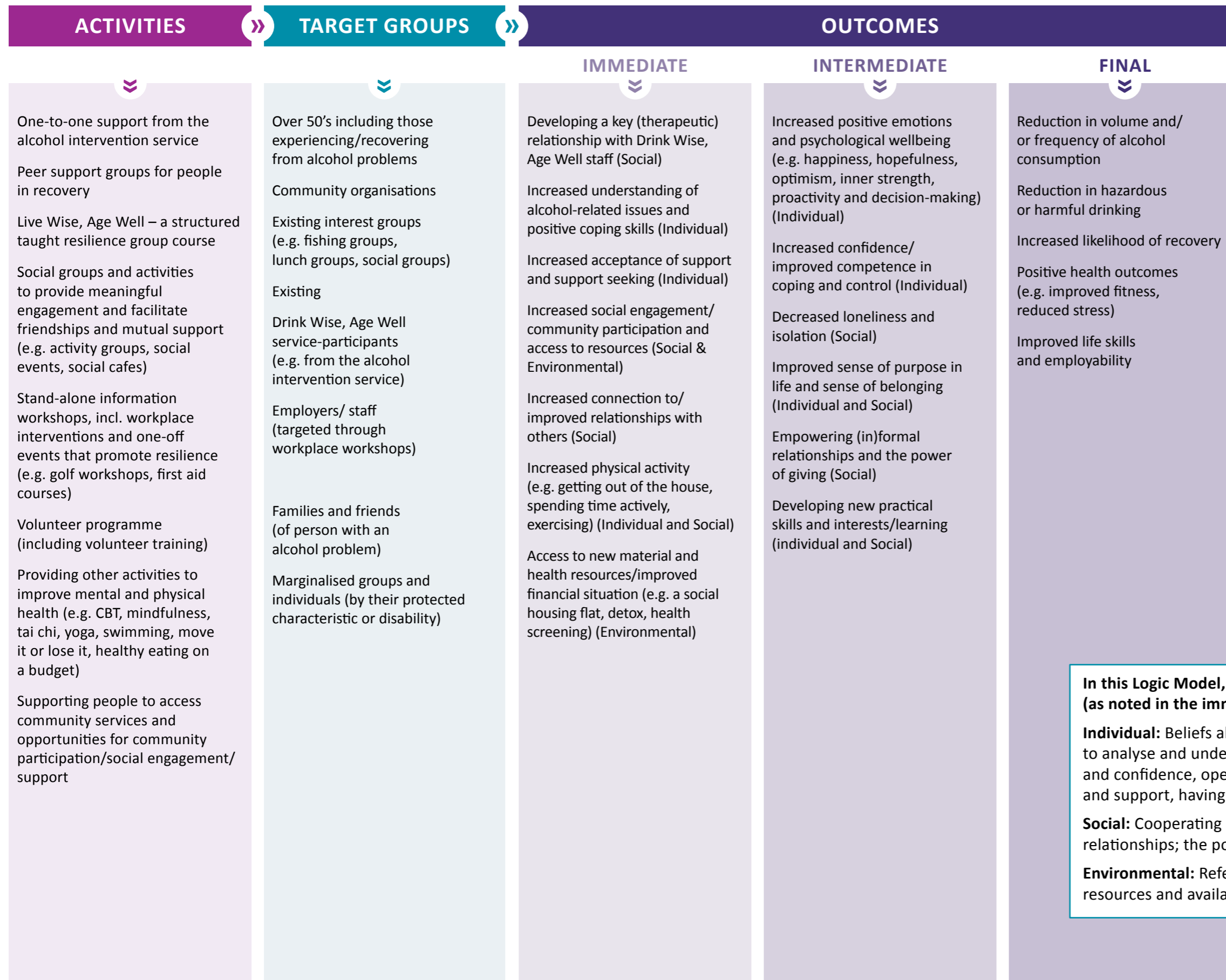
Drink Wise, Age Well successfully increased resilience among older adults and delivered the support needed to reduce hazardous or harmful drinking among adults over 50.

It did so at three levels: through developing individual resilience; developing resilience alongside others (social resilience); and gaining resilience by accessing other services and opportunities (environmental resilience). However, those in recovery who only participated in the alcohol intervention service (i.e. received one-to-one support) were less likely to benefit from the other forms of resilience.

A quantitative assessment of the Live Wise, Age Well course indicated its varied success in terms of developing resilience at individual level (as measured by the Brief Resilience Scale). The majority (70%) of participants entered and exited with the same level of resilience, which may indicate a preventive function of the course. In terms of harm reduction, the course appeared most beneficial for those who had low levels of individual resilience at entry. Of these, 48% reported normal levels of resilience by the end of the course compared with 5% of those who reported normal levels of resilience at entry and high at the end.

It is hard to predict whether recovering drinkers, and particularly single men living on their own, will be resilient in the longer-term without sustained external motivation and support to maintain lower drinking levels. The impact of Drink Wise, Age Well on preventing hazardous or harmful alcohol use is more difficult to evidence and hence less clear. Nevertheless, data from social activities, social groups and the Live Wise, Age Well programme points to the effectiveness of alcohol prevention measures through building resilience. Therefore, it is likely that increasing resilience will have reduced the extent to which people will use alcohol to cope with difficult circumstances.

LOGIC MODEL: INCREASING RESILIENCE



TESTING THE ASSUMPTIONS

We consulted research literature to explore whether the logic behind the key areas of activity was appropriate, including examining the basis of any theoretical assumptions made. The assumptions we considered were:

- Is there evidence that increasing positive emotion, adaptive coping strategies, social support and participation will increase overall resilience in older adults and lead to changes in hazardous or harmful drinking behaviour?
- Is there evidence that older adults do not receive the support they need to reduce hazardous or harmful drinking behaviour, including support for increasing resilience?

In this Logic Model, we distinguish between three domains of resilience (as noted in the immediate and intermediate outcomes):^[51]

Individual: Beliefs about one's competence; efforts to exert control; capacity to analyse and understand own situation. Examples include: inner strength and confidence, openness about own vulnerability, the acceptance of help and support, having a balanced vision on life;

Social: Cooperating and interacting with others; empowering (in)formal relationships; the power of giving;

Environmental: Refers to the broader environment one lives in, material resources and available forms of formal support, such as accessibility of care.

Understandings of resilience

Definitions of resilience are numerous and vary significantly. For example, Joyce et al.^[52] defined resilience as being able to function in everyday life despite ongoing stress while Luther et al.^[53] defined resilience as the ability to adapt positively to stressful circumstances. Both definitions place the responsibility for being resilient on the individual, and their ability to 'function' and 'adapt' under stressful circumstances. This ties in with certain policy approaches towards resilience which create an expectation that people should 'bounce back'.^[54]

Meanwhile, whilst resilience is an important quality to cultivate in individuals, it should not be seen as an antidote to the impact of poverty, marginalisation, discrimination and social exclusion. It has been argued that such broader socio-political factors play a key role in one's ability to be (come) resilient.^[54-56] Indeed, such factors may either facilitate or hinder developing personal resilience. For instance, positive social and economic capital (such as a safe and nurturing environment, having positive role models, being financially secure, having access to employment or other meaningful activity), positive cultural influences (e.g. increased awareness and acceptance of mental-health issues, or in the case of alcohol users - increased availability of non-alcoholic beverages, increased availability of information on the negative effects of excessive drinking), and access to support services are all factors facilitating developing resilience.

However, factors such as social isolation, austerity, lack of employment opportunities, negative cultural influences (e.g. stigmatisation of certain groups, or in the case of alcohol users - aggressive alcohol marketing, a cultural shift from drinking in pubs to drinking at home), lack of support services, and a generally non-supportive political climate and policy approaches (e.g. in the case of older drinkers - the current social policy focus on younger people) may have negative impact on an individual's resilience. Therefore, an individual's resilience cannot be seen as separate from and independent of the broader social, economic and political factors shaping their everyday lives.

Considering the significance of broader factors for individual resilience, it has been argued that the process of developing resilience spans three different domains:^[51]

- the individual domain, which consists of self-beliefs (including belief in one's ability to change), efforts to exert control, and the capacity to analyse and understand one's own situation;
- the interactional (social) domain, which refers to cooperating and interacting with others to achieve personal goals, and having empowering (in)formal relationships;
- the contextual (environmental) domain, which refers to the aforementioned broader political-societal climate, including accessibility of care and availability of material resources.

Consequently, any interventions aimed at developing one's resilience should cover all three domains rather than focus on the individual alone.

Resilience and alcohol consumption in older adults

Following the definitions of resilience cited in the previous section, resilience can be seen as key to dealing with stress. This is highly significant when considering older adults for whom stress is a leading factor in the development of an alcohol dependence later in life.^[57] Stress may be defined as 'a state of mental or emotional strain or tension resulting from adverse or demanding circumstances'.^[58] Research suggests that there are a number of factors which may lead to older adults feeling stressed, including significant life events such as retirement, bereavement and divorce.^[59] Several studies highlight that during such times alcohol use may be less controlled, secretive or generally heavier.^[60]

A 2015 Drink Wise, Age Well survey showed that the five most common self-reported reasons for drinking more in later life were: retirement (40%), bereavement (26%), loss of sense of purpose in life (20%), fewer opportunities to socialise (18%), and change in financial circumstances (18%).^[61] Indeed, retirement can be a particularly distressing time for older adults as it brings with it many changes which can contribute to a loss of identity and purpose, and disruption to routine.^[57]

An increasing body of evidence supports the view that retirement may negatively affect alcohol consumption. For example, a recent cohort study of 5805 public sector employees found that alcohol consumption increased for 12% of employees at the time of retirement to risky levels defined as 24 units per week among men and over 16 units among women, or an extreme drinking occasion during the past year.^[62]

Divorce also appears to affect alcohol consumption. According to a recent study of 10,457 adults, divorced men over 60 were more likely to exceed alcohol recommendations and women aged 60 were more likely to drink heavy when compared to married men and women of the same age.^[63] Bereavement is another significant life event that has been shown to have an impact on alcohol use in older adults.^[64] The aforementioned events in an older person's life are among the most difficult experiences that they will face during their lifetime.



Other difficult experiences at this stage of the life course are connected with the physical effects of ageing and deteriorating health. This may result, among others, in physical disabilities, chronic pain, insomnia, sensory deficits, reduced mobility, or cognitive impairment. Older adults thus may suffer an impaired ability to function and a consequent loss of independence.^[65]

Furthermore, older adults are at greater risk of being socially isolated than younger people^[66] including 'digital exclusion' – a lack of access to modern technology or confidence in using it. Therefore, they are less likely to use social media for formal and informal support.^[67] Isolated older adults frequently suffer feelings of loneliness^[68-69] which may impact on increased drinking levels, as demonstrated by Hanson.^[70] Hanson's study of the relationship between social networks and heavy drinking was based on a random sample of 500 men, all 68 years old at the time of the study. Results showed that heavy drinkers were more likely to live alone, had fewer contacts with friends and family, less participation in social events, and a less integrated social network.^[70]

Nevertheless, while some older adults may turn to alcohol to deal with difficult situations, others manage to cope without the use of such maladaptive coping strategies. There is increasing interest in low resilience and the use of maladaptive coping strategies such as hazardous or harmful drinking, a so far under-researched association in older adults. In a study of 300 older adults aged 60+ years,^[71] 47% of hazardous and harmful drinkers were found to have low resilience. This reflects the results of studies on younger populations, for example Wingo et al.,^[72] studied a younger yet larger population of 2054 men and women. This study found that resilience was associated with a reduced risk of alcohol and substance use problems among adults who experienced traumatic experiences. Resilience was also associated with a reduced risk of mental health problems, such as depression, PTSD and suicide.^[72] There is thus increasing interest in the impact of resilience interventions, especially as high resilience has been shown to be linked to positive adaptive coping. This is believed to be critical to recovery from stressful life events, which are naturally more likely to be experienced by older adults.^[73]

Support for older adults to reduce drinking and increase resilience

Drink Wise, Age Well, a specific service for people aged 50 and over, was developed in response to the need for services supporting resilience building and controlling alcohol use among this age group in particular. Such provision within the UK has been very scarce: while a 2004 alcohol needs assessment study found less than 1% of services in England provided a service specifically for older adults,^[74] and a 2011 research study identified as few as five substance misuse agencies which had an older adult's service across the whole country,^[18] these were no longer in operation by June 2015 when Drink Wise, Age Well was launched.^[75] Meanwhile, accumulating evidence indicates that older adults' services may be linked to better treatment outcomes and adherence than mixed-age services.^[12-16] This can be largely ascribed to the particular challenges older dependent drinkers face in accessing support adequate to their specific needs.

As mentioned before, older adults go through particular life changes connected with their life stage, such as retirement, loss of friends and social status, becoming a carer for an elderly partner or family member, bereavement, deteriorating physical health, and loss of independence.^[65] Older drinkers hence have different stressors, precipitating factors and risk factors for relapse than younger drinkers. At the same time they face a number of unique barriers to accessing mainstream services and are more likely to remain 'hidden' from these.^[18]

An initial Drink Wise, Age Well evaluation of the need for alcohol services for older adults demonstrated that whilst these are needed, obtaining and sustaining funding for such targeted services is very difficult. At the same time it was acknowledged that trying to meet the specific needs of older adults (such as home visits or support with getting to medical appointments) through mainstream alcohol services is equally difficult due to their limited capacity.^[75] Moreover, the Drink Wise, Age Well programme recognised the need for a preventative approach that focused on raising awareness of alcohol harm more generally and improving resilience in the wider community. Therefore, staff also aimed to enhance resilience and coping skills of older adults with the intention of preventing hazardous or harmful drinking.^[76]



EVIDENCE IN RELATION TO THE LOGIC MODEL

IMMEDIATE OUTCOMES	
OUTCOME	EVIDENCE SUMMARY
Developing a key (therapeutic) relationship with Drink Wise, Age Well staff	<p>Various qualitative data sources demonstrate that the relationship with the Drink Wise, Age Well staff and their approach to the people they supported was extremely important to participants. This relates to people engaging with various Drink Wise, Age Well services, from the alcohol intervention service to social groups. However, due to the intensive nature of the one-to-one support, for alcohol intervention service participants the relationship with their key worker was fundamental to their journey to recovery.</p> <p>Many programme participants receiving alcohol intervention commented that it was the positive experience of first contact with a Drink Wise, Age Well worker that motivated them to further engage with the service. They saw the supportive, non-judgemental and non-stigmatising approach of Drink Wise, Age Well staff, as well as the individual support they offered, as key to their recovery.</p>
<p>“ Alcohol intervention service worker wasn’t clock watching, she was able to give me her time... (...) [S]he came to my house, there would be times if I was really going for it and it was all coming out because it does, you realise what you’re doing to yourself and it’s a very emotional time (...). I think you need to form a bit of a bond and a trust with whoever it is that’s trying to counsel you, or to try and help you... I’ve got a very strong bond with [alcohol intervention service worker] as my mentor... She saved my life as far as I’m concerned.</p>	
<p>“ I’ve had slips but they have, Drink Wise, Age Well, have been very, very, supportive to be honest with you. They, you know, they’re always there for me, you know, and like that when I feel so guilty about drinking, picking up drinking all that they’re so, so, supportive with me. So I keep trying again and trying again.</p>	
	<p>The relationship with their key worker was crucial to all alcohol intervention service programme participants but in the long run even more so to those who could not or would not engage with broader Drink Wise, Age Well activities due to e.g. mental health issues or a personal preference. In such cases the relationship with their Drink Wise, Age Well case worker alone was fundamental for their resilience-building and recovery journey.</p> <p>Older adults involved in other Drink Wise, Age Well activities likewise underlined the significance of the staff’s caring, considerate, supportive and non-judgmental attitude towards them. As a group activities participant said:</p>
<p>“ I always say [Drink Wise, Age Well worker] saved my life, she’s so caring, even after the first meeting she asked how was I and (...) she texts me and reminds me that the groups are on, otherwise I would forget (...). She’s so kind and caring and she’s made a big difference to me, just her texting me and having a chat, she’s lovely. It’s nice that you know somebody cares about you.</p>	

IMMEDIATE OUTCOMES	
OUTCOME	EVIDENCE SUMMARY
	<p>This openness encouraged engagement with the activities as well as other participants. As participants of a Live Wise, Age Well course explained:</p>
<p>“ And those two people that run that programme, they were excellent. They allowed us to talk to and reach out to others. To express your views. They listened to you. [T]hey are nice people to talk to and to listen to. Drink Wise, Age Well participant</p>	
	<p>Therefore, for participants of Drink Wise, Age Well the positive relationship with Drink Wise, Age Well staff was key to their engagement with the programme and developing resilience.</p>
Increased understanding of alcohol-related issues and positive coping skills	<p>Drink Wise, Age Well successfully increased understanding of healthier drinking limits and strategies for coping with excessive alcohol consumption, as borne out by both quantitative and qualitative data. This was done through a number of activities: the alcohol intervention service, peer support groups, standalone information sessions and workshops (e.g. in public spaces or the workplace), and social activities.</p> <p>Participants of all these activities reported gaining a better understanding of how to cope with alcohol issues. For example, 75% of participants of standalone information sessions agreed or strongly agreed that their knowledge and understanding of alcohol had improved, and 86% said they would know where to go and get help should they or their families need it. Standalone sessions attendees also commented how they only understood units and how much time it took to get them out of their system thanks to the Drink Wise, Age Well session:</p>
<p>“ Even at the time that they were telling you how long it took to get [alcohol] out of the system. A unit takes an hour. A lot of people weren’t aware of that and they were then quite shocked at how slowly it takes to go out of your system when they’re going to the work the next day or driving their kids to school, that kind of thing.</p>	
	<p>The alcohol intervention service programme participants repeatedly underlined how gaining an understanding of their own alcohol consumption and ways of managing it was a crucial first step in learning to control their drinking and building resilience. Alcohol intervention service key workers helped people with alcohol problems draw up personalised coping strategy plans based on their personal circumstances and goals. Programme participants found these extremely helpful:</p>
<p>“ Coming to understand your dependency... drink diary, realising the scale of the problem. She [alcohol intervention service worker] built that into the goal... try it, don’t go to the pub.</p>	

IMMEDIATE OUTCOMES

OUTCOME	EVIDENCE SUMMARY
	<p>Family members of people with alcohol problems and Drink Wise, Age Well programme participants who did not have an alcohol problem also commented on the usefulness of being aware of healthy limits and how to support others with an alcohol problem. Participants of Drink Wise, Age Well activities which were non-alcohol focused but included sharing knowledge on healthy drinking and coping strategies also appreciated becoming more aware of alcohol-related issues. Some admitted that acquiring new knowledge made them realise they were drinking above the healthy alcohol limits and needed to re-gain control of their drinking:</p> <p>“ Drink Wise, Age Well I would say absolutely educated me about drinking. It really, that knowing what I was doing, what I was dealing with, how it was affecting my health. How it was affecting my kids’ lives, my kids never knew how much I drank because I lived on my own (...). [And] I came off vodka completely ‘cos I just knew that it would, the horrendous effects it was having on me.</p> <p>The usefulness of learning about alcohol units in practice and what constituted safer drinking was underlined repeatedly by those participating in Drink Wise, Age Well activities. They saw gaining this knowledge and awareness as very helpful in controlling their own drinking, especially when drinking at home. They also felt more aware of others’ hazardous or harmful drinking and inclined to share their newly gained knowledge with other people.</p>
<p>Increased acceptance of support and support seeking</p>	<p>Participation in the various Drink Wise, Age Well activities was found to increase acceptance of support and seeking further support. If this related to alcohol issues in particular, it was offered directly by Drink Wise, Age Well. Otherwise, Drink Wise, Age Well facilitated getting further support through information sessions and working partnerships with other support organisations.</p> <p>Over 50s who had an alcohol problem were referred to the alcohol intervention service (5,800 referrals) and/or the peer support groups (1,096 attendees) in the first instance. Qualitative data demonstrates that a number of alcohol intervention service/peer support group participants, especially those who had previously unsuccessfully engaged with other alcohol services, had issues with seeking and accepting support prior to engaging with Drink Wise, Age Well. The various support channels offered by Drink Wise, Age Well coupled with the non-judgemental, caring approach of the staff facilitated participants’ acceptance of help and encouraged looking for further support. For example, the person-centred approach within the alcohol intervention service was particularly valued by programme participants whose needs could not be met by mainstream services, e.g. due to mobility or mental health issues:</p> <p>“ I was first introduced to Drink Wise, Age Well after being given a leaflet whilst I was in police custody in 2018 (...). After a lifetime of using services I was quite cynical about reaching out for help - I asked myself, what difference they could make (...). I was surprised and relieved at the obvious care, compassion and efficiency I experienced after contacting Drink Wise (...). It is now 6 months later (...), I'm receiving counselling weekly and have been given help in engaging mental health services.</p>

IMMEDIATE OUTCOMES

OUTCOME	EVIDENCE SUMMARY
	<p>Moreover, hazardous/harmful/recovering drinkers who attended peer support groups underlined that connecting with peers in a similar situation to their own very much helped them open up about their problems. Peer support group participants often went on to engage in the non-alcohol focused social activities provided by Drink Wise, Age Well.</p> <p>The vast majority of Drink Wise, Age Well programme participants engaged in the non-alcohol focused activities for which referrals were not needed: social activities (4,607 attendees), events (5,719), and the Live Wise, Age Well taught course (2,466 attendees). Engagement in these activities can be interpreted as support seeking in itself: for many participants this was a way of addressing their loneliness and isolation. Furthermore, engagement in Drink Wise, Age Well activities often motivated seeking further help. Information sessions on where to find support for various issues related to older age, such as bereavement, pensions or employability were greatly valued, and some participants had contacted the recommended agencies in result. As a social activity participant commented:</p> <p>“ Anything that you're worried about, about the NHS or your care or your husband’s care, they were there to advise people if they’d got any worries, which I had plenty of worries at the time!</p> <p>For some Drink Wise, Age Well social activity participants who did not initially identify as hazardous or harmful drinkers, the awareness-raising activities led to seeking support to manage their drinking.</p>
<p>Increased social engagement/ community participation</p>	<p>A core part of the Drink Wise, Age Well intervention programme focused on activities which would increase social engagement and facilitate access to resources. These have been highly successful in achieving their goals with both quantitative and qualitative data confirming that Drink Wise, Age Well increased beneficiaries’ community participation and social engagement levels. For instance, 75% of social activity participants agreed that Drink Wise, Age Well improved their community participation levels and this was reiterated in qualitative accounts:</p> <p>“ I know I have benefitted in a big way because I hadn’t been out in ages, and now I have started going to some groups.</p> <p>A number of programme participants mentioned that Drink Wise, Age Well opened new opportunities for social engagement and accessing resources for them, often where these were highly limited beforehand, e.g. due to personal circumstances such as being a carer, or mobility or transport issues. In some cases, participants were heavily supported in increasing their community participation. For example, some (especially beneficiaries of the alcohol intervention service) were taken to activities by their case workers until they gained the confidence to start going to these independently.</p>

IMMEDIATE OUTCOMES

OUTCOME	EVIDENCE SUMMARY
	<p>Drink Wise, Age Well thus played a crucial role in providing access to and facilitating engagement in social activities for its programme participants, especially for isolated individuals and in areas where such opportunities were previously highly limited or unavailable. As social group and activities participant said:</p> <p>“ Being a single person living on my own, it gave me the opportunity to meet a lot of people in the community and getting back into the local community.</p> <p>“ I think it was important for me personally to actually make sure I got out because I could sit at home all day, so I think it was important and also important to make another circle of friends because quite often your friends are your work people, so it was just to go out and do something different, to make sure I didn't stay in the house all the time.</p>
<p>Increased connection to others and improved relationships</p>	<p>Supporting people in establishing connections with others is one of the key outcomes of Drink Wise, Age Well, evidenced by both quantitative and qualitative data. For example, evaluations of social activities showed that 96% of programme participants found these encouraged them to engage with others, 80% felt their relationships improved and 75% felt their community involvement improved. Increased connection to others resulting from engagement with Drink Wise, Age Well was often mentioned by programme participants:</p> <p>“ I have a very high opinion of the project. It has greatly helped me as I have always been very socially isolated.</p> <p>A number of Drink Wise, Age Well social activity participants were previously isolated due to retirement, family circumstances or health problems. Drink Wise, Age Well helped many make new friends, and in some cases establish very close friendships:</p> <p>“ I lost all my friends through looking after my husband with dementia, I don't know why, they drop you off, but this one I've found [through Drink Wise, Age Well] and she got a husband with dementia, same type of problems (...). [A]nd so we have started once a week going somewhere together, just having a day out together so it's nice. [W]e're in similar [Drink Wise, Age Well] groups together and we've just had a week's holiday together, which we desperately needed. [I]t were best holiday we've had, it was lovely.</p> <p>Therefore, many participants reported that social activities not only expanded their social network but also normalised their social relationships.</p>

IMMEDIATE OUTCOMES

OUTCOME	EVIDENCE SUMMARY
	<p>Programme participants repeatedly underlined the crucial role of building strong connections to others for their wellbeing and, in the case of hazardous or harmful drinkers, for their recovery journey. The alcohol intervention service programme participants stated taking part in the programme also helped them improve existing relationships with family and friends. This was reported both by people with alcohol issues and by 'concerned others' receiving support (usually family members). For people with alcohol issues, relationships improved in result of opening up and speaking about their problems along with working towards recovery and gaining control over their drinking. Some participants mentioned reconnecting with partners, children and grandchildren, in some cases after many years of limited or no contact:</p> <p>“ Most importantly, I am back in contact with my daughter and grandchildren. We see each other every week and spend time baking together.</p> <p>On the other hand, family members felt knowing how to cope with their loved one's drinking helped improve communication and relationships within the family:</p> <p>“ I don't think it [my wife starting to drink again] will have the same impact as what it used to have because I feel more confident, more stronger, more able to deal with things better now...[and]...instead of walking on glass... I'm able to talk to her now.</p>
<p>Increased physical activity (e.g. getting out of the house, spending time actively, exercising)</p>	<p>Participating in Drink Wise, Age Well social activities resulted not only in increased levels of connection with others but also of physical activity. Some activities, such as exercise classes or walking groups, were focused on this goal in particular. Yet even if this was not the primary goal of an activity, the sheer need to get out of the house entailed increased physical activity for many participants, especially those who were previously spending most of their time indoors:</p> <p>“ [My key worker] is very proactive, she said 'we need to get you out of the house and getting you doing things.' So that's what I did. I was doing arts and crafts, health walks and going to the allotment. More outdoorsy kinds of things.</p> <p>“ It was very helpful to think about when they talked about going to swimming [at the Live Wise, Age Well course], I started swimming after that. [A]nd I did the walking, started walking.</p> <p>“ Before I started doing this voluntary work [running a Drink Wise, Age Well crafts group], I suffered really badly with depression. Some days I never used to go out of house or anything. In fact I didn't even bother getting ready and I stayed in bed most of the time.</p>

IMMEDIATE OUTCOMES

OUTCOME	EVIDENCE SUMMARY
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Gaining access to new material and health resources (e.g. a social housing flat, detox, health screening, exercise classes)

Drink Wise, Age Well provided programme participants with access to many new resources. Apart from access to various activities, they also provided access to information and direct access to new material and health resources, especially for those receiving one-to-one support.

The alcohol intervention service provided high levels of practical support to hazardous or harmful drinkers, enabling participants to access new material and health resources. Alcohol intervention key workers helped participants to e.g. enrol in rehab, attend medical appointments, enrol in courses, or apply for social housing. The level of practical support provided by the service and the time they could devote to an individual was seen as a unique and very helpful, especially for those whose needs could not be met by mainstream services:

“ A hell of a lot of difference [between local mixed age alcohol support service and the Drink Wise, Age Well alcohol intervention service] because I knew there was no time limit, ...alcohol intervention service worker wasn't clock watching, she was able to give me her time... (...) With Drink Wise, she came to my house, there would be times if I was really going for it and it was all coming out because it does, you realise what you're doing to yourself and it's a very emotional time, at that time ...you can't suddenly say 'I've got to go now' because you would ruin all that good work....

“ She [alcohol intervention service worker] used to come to the house and take me down to [peer support group meetings] at that time because I wouldn't go on a bus, or [I was] frightened to go outside ... I feel as if, through their help ... I'm getting more confident, and I was starting to go on a bus myself and go to the [peer support group] meetings.

Drink Wise, Age Well also provided support in accessing new material and health resources to social activity and group programme participants. For instance, Drink Wise, Age Well provided transport to social activities for a number of participants. It also offered advice sessions on managing finances or pension plans, helping participants improve their financial situation. Most importantly, the overwhelming majority of Drink Wise, Age Well activities were provided for free, including various exercise classes aimed at boosting participants' physical and mental health, such as dance, yoga, or mindfulness. The fact they were free and widely available was very much appreciated:

“ I think that what they do is they realise what the problem is. Like, for example, when you go to the café on a Thursday they pay for the coffees (...). One of the days you wouldn't go because, oh I've got to go into town and pay a few quid for a cup of coffee or whatever it is. Do you know what I mean? So they provide the coffee.

“ [The Drink Wise, Age Well class is] free, rather than being a pay class, which makes a bit of a difference.

INTERMEDIATE OUTCOMES

OUTCOME	EVIDENCE SUMMARY
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Increased positive emotions and psychological wellbeing (e.g. happiness, hopefulness, optimism, inner strength, making the decision to change)

Both quantitative and qualitative data demonstrate that Drink Wise, Age Well impacted positively on programme participants' feelings of wellbeing, bringing back a sense of hope in the participants' lives, helping them feel better about themselves, more fulfilled, and more confident. There was a general sense of enjoying life more:

These feelings are reflected in various wellbeing scores and survey data. 46% of participants who completed the Live Wise, Age Well taught resilience course declared feeling optimistic about the future often or all of the time, 51% feeling useful and 48% feeling relaxed. As a result of taking part in social activities, 79% participants reported that their emotional health improved and 82% that their sense of purpose improved, and in 80% their relationships with others improved. Similarly, feedback from peer support groups found participants felt they had experienced improvement in emotional health (85%), sense of purpose (84%), and relationships with others (79%). Furthermore, alcohol intervention service participants also demonstrated a clear increase in their general well-being over the course of the intervention and six months after discharge. For 74%, positive mental health scores (measured by Short Warwick Edinburgh Mental Wellbeing Scale or S-WEMBS) increased between assessment and discharge. The Patient Health Questionnaire (used for measuring severity of depression) demonstrated an improvement in mood over time. For example, 227 (19%) of the total sample (1484) reported severe depression at entry to the intervention and of these 81% reported an improvement at exit from the intervention. Similarly, alcohol intervention service participants experienced a decrease in anxiety levels (as measured by the Generalised Anxiety Disorder tool). For example, 409 (28%) of the total sample (1469) reported severe anxiety at entry to the intervention and of these 70% (n=282) reported an improvement at exit from the intervention.

“ I'm working, I'm happy (...), I'm fit mentally and physically and that started three years ago [with Drink Wise, Age Well] here.

Increased confidence and improved competence in coping and control

Participating in various Drink Wise, Age Well activities helped build confidence in different ways, as evidenced by qualitative data. For instance, initial assistance from the alcohol intervention service helped the most vulnerable programme participants gain the confidence to start travelling independently, engage with others, or go to activities by themselves. Moreover, many programme participants mentioned their confidence growing as they attended Drink Wise, Age Well workshops and started learning new skills or refreshing skills they already had. The volunteering programme also played a crucial role in building confidence in the volunteers' own abilities:

“ Volunteering gives me something to do. (...) I'm so much more confident too. I've done a lot of training in everything from First Aid to communication skills, that all helps you feel like you know what you are doing.

Therefore, Drink Wise, Age Well provided many programme participants with a confidence boost and strengthened their general coping skills. Increased competence in coping and control of alcohol-related challenges in particular were reported by both alcohol users and family members taking part in Drink Wise, Age Well interventions:

“ I have regained control over my finances and worked hard to build up my confidence. I can manage family disagreements and stressful situations better, rather than using alcohol as a way to cope. I now feel confident enough to access counselling which has helped my mental health.

INTERMEDIATE OUTCOMES

OUTCOME	EVIDENCE SUMMARY
<p>Decreased loneliness and isolation</p>	<p>Drink Wise, Age Well achieved considerable success in decreasing levels of loneliness and isolation among programme participants, as evidenced by quantitative and qualitative data. For instance, 63% of people who completed the Live Wise, Age Well course declared they felt close to other people often or very often and 75% of social activity participants said that attending these had improved their involvement in their community. These figures were reflected in qualitative interviews: people who participated in social activities, social groups and peer support groups repeatedly underlined how much these helped them combat loneliness and isolation:</p> <p>“ It was a God send for me. I was so lonely and feeling down.</p> <p>“ When I was by myself and secret drinking, you do feel extremely lonely. Very, very lonely and you feel as though you’re the only person that’s going through it. So to be able to get out and about, meet people with shared experiences, it’s what’s helped me the most.</p> <p>“ I was feeling very isolated and I wanted a small group to join, not too far to travel. (...) I come in [to the crafts group] when I can (...), it’s a really lovely group.</p>

<p>Improved sense of purpose in life and sense of belonging</p>	<p>Qualitative and quantitative evidence demonstrate participating in Drink Wise, Age Well interventions improved participants’ sense of purpose and belonging. These could be developed in a number of ways, e.g. through gaining control over one’s alcohol problems and re-establishing relationships with family and friends; making new friends; learning a new skill or brushing up on an old one; being involved in running activities or supporting others. As a Drink Wise, Age Well volunteer reflected:</p> <p>“ I just love it [volunteering with Drink Wise, Age Well]. It’s very much, it keeps me in a routine which I was used to because I worked all my life and then when I took early retirement the routine was out the window. So now, no, I’m up every morning. I’ve got a purpose to go out. I’ve got a reason to go out and just thoroughly enjoy it meeting so many nice people and doing things that I never dreamed I would do.</p> <p>Survey data also point to an increase in feelings of having a purpose in life. For instance, 84% of peer support group participants and 82% of social activity participants felt their sense of purpose had improved since they started attending the groups/activities.</p>
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INTERMEDIATE OUTCOMES

OUTCOME	EVIDENCE SUMMARY
<p>Empowering (in)formal relationships and the power of giving</p>	<p>Drink Wise, Age Well provided many opportunities for establishing relationships with others as well as providing (mutual) support. Extensive qualitative data demonstrates their empowering effect on participants. Both drinkers and non-drinkers perceived developing a circle of support as a crucial improvement in their lives. Having others they could share experiences with, get encouragement from or count on in need provided participants with feelings of comfort and reassurance. They had also experienced the power of giving - be it through sharing experiences, providing advice to others or becoming a volunteer. Being with others and doing things for others made participants feel stronger and more resilient to adversities and the impact of change:</p> <p>“ The Hopefuls group run by Drink Wise, Age Well helped me meet other people who were struggling with their drinking. Friendships were formed and I loved the trips we went on as a group. All the time I could feel my confidence coming back and I also found the courage to be more assertive and say ‘no’ to people who do not have my best interests at heart.</p> <p>“ I got a sense of purpose [from volunteering], a reason to get out of bed in the morning...focus. It’s true you do want to put something back, but it’s about your own recovery as well. It’s always nice to put something back but to actually get out and be able to help people a little bit, you get a good feeling out of it.</p>

<p>Developing new practical skills and interests/learning</p>	<p>Drink Wise, Age Well delivered many activities where programme participants could learn a skill (e.g. cooking, gardening, art, singing, IT) or gain new knowledge (e.g. about mind and memory, healthy eating, alcohol). As testified by qualitative data, participants highly valued the opportunity to develop new skills and interests, and to learn new things. Such activities brought them great joy and a sense of achievement, helping to improve their confidence. In some cases, participants were rediscovering old skills and passions, such as painting. Participants commented on the therapeutic value of participating in workshops:</p> <p>“ Very enjoyable - friendly, warm atmosphere. Therapeutic and encouraging.</p> <p>Some became so interested and involved in a given activity that they went on to lead it as a volunteer, e.g. a participant of a Mind and Memory programme in Sheffield.</p> <p>Therefore, while for all participants developing new skills and interests was a valuable confidence-building experience and way to keep their mind active, for some it became a pathway into volunteering and in some cases, eventually into paid work.</p>
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FINAL OUTCOMES

OUTCOME	EVIDENCE SUMMARY
<p>Reduction in volume and/or frequency of alcohol consumption</p>	<p>Drink Wise, Age Well programme participants across the board achieved considerable success in reducing the volume and frequency of alcohol consumption, as borne out by both quantitative and qualitative data.</p> <p>With regards to people who entered Drink Wise, Age Well as hazardous or harmful drinkers, the majority greatly decreased their alcohol usage. For instance, 63% of the alcohol intervention programme participants who were drinking above weekly guidance at entry had stopped drinking or reduced weekly drinking by half or more at discharge. In interviews, alcohol intervention programme participants often spoke about reducing their drinking:</p> <p>“ In rough terms, I would possibly do 60-70 units a week... I'm now down to sort of 25-30 units, which is still over the recommended issue... I do want to reduce that... and the way I've reduced it, I don't have foggy mornings anymore... [and I don't] get up in the morning and have a drink... ”</p> <p>“ I found [my key worker] to be very inspirational and as a direct result of our meeting I stopped drinking... he's revived my passion for music and I currently sing with 2 choirs. ”</p> <p>Similarly, programme participants who attended peer support groups only (and did not receive any other interventions from Drink Wise, Age Well) reported a considerable reduction in drinking levels: 48% stopped drinking and 40% reduced their alcohol use since they started attending the groups. Again, this was reflected in qualitative accounts:</p> <p>“ The meetings are great. I've got so much help here, every time I come, I get help. The meeting for me is an anchor. Now, I'm not coming now, I'm not coming now because of drinking at all, I come now just with life issues because there's two parts, there's Drink Wise, for me Drink Wise is complete abstinence for me. ”</p> <p>Notably, participants of non-alcohol focused activities also reported a decrease in levels of drinking, with 38% of social activity participants declaring they had reduced their drinking since attending the activity.</p>

FINAL OUTCOMES

OUTCOME	EVIDENCE SUMMARY
<p>Reduction in risk of hazardous or harmful drinking</p>	<p>Qualitative data confirm Drink Wise, Age Well interventions helped build participants' resilience and reduce the risk of hazardous or harmful drinking. For instance, most alcohol intervention programme participants reported that involvement in the service helped to promote recovery and reduced their risk of relapse. The same was stated by participants of other activities: attending peer support groups, volunteering and attending social activities and groups were all thought to help build the participants' resilience and counter risks of increased levels of drinking:</p> <p>“ [The session facilitator] gave out the measures (...) so there was wee measuring glasses (...), I still use that for my wine. [You] can keep a better track of what you're drinking. You think you're only having one glass of wine but... ”</p> <p>The support programme participants gained from Drink Wise, Age Well interventions helped when alone and at risk of drinking:</p> <p>“ [Drink Wise, Age Well] gives you time to...well it makes you connect, you remember what they've said to you.....And although it's acceptable, you try not to pick up the drink and it just gives you that wee thing do something else. ”</p> <p>The fact that 38% of social activity participants (who were not identified as hazardous or harmful drinkers) declared reducing their drinking levels since attending the activities may also be interpreted as indicating a reduction in risk of hazardous or harmful drinking.</p>
<p>Increased likelihood of recovery</p>	<p>Qualitative data evidence that through helping build resilience, Drink Wise, Age Well interventions increased programme participants' likelihood of recovery. Drink Wise, Age Well strengthened resilience at an individual level but also within the social domain (through helping develop stronger social ties), and environmental domain (through providing access to various resources). Many of the recovering dependent drinkers expressed how they had (re)gained control of their life in result of the intervention:</p> <p>“ It is now 6 months later, I have my life back on track and my drinking is now under control (...). I'm receiving counselling weekly and have been given help in engaging mental health services. I have my relationship and my home back. I am returning to work shortly and have regained my self-respect. ”</p> <p>Importantly, programme participants wished to maintain the positive status quo they had worked towards with Drink Wise, Age Well. While a few participants had reported a lapse at some point, those who had returned to Drink Wise, Age Well continued their recovery journey, hence increasing the likelihood of (full) recovery.</p>

FINAL OUTCOMES

OUTCOME	EVIDENCE SUMMARY
<p>Positive health outcomes (e.g. improved fitness, reduced stress)</p>	<p>Drink Wise, Age Well activities also resulted in a number of positive health outcomes (other than reduced drinking), as evidenced by both quantitative and qualitative data. Drink Wise, Age Well interventions resulted in considerable improvements in mental health. The practical support received to help address anxiety-triggering everyday issues, learning how to cope with drinking, reducing loneliness and establishing closer connections with other people, and taking part in activities of interest were all seen as helping reduce stress levels among dependent drinkers. Concerned others supported by Drink Wise, Age Well also showed improvements in mental health with stress levels reported at admission and discharge from the programme dropping by 50%. 85% of peer support group attendees reported an improvement in emotional health. Similarly, Live Wise, Age Well and social activity programme participants reported improvements in mental health. 48% of Live Wise, Age Well participants reported feeling relaxed and 46% feeling optimistic often or all of the time at the end of the programme, and 79% of social activity participants said they felt their emotional health had improved.</p> <p>Limiting alcohol use positively impacted on other health issues, too:</p> <p>“ I'm seeing [the benefits of reducing drinking] now, from going to the doctor's, I'm getting response on the diabetes ... blood pressure ... now it's pretty good</p> <p>Many participants, especially those of social activities requiring physical activity also commented on a general improvement in their fitness levels:</p> <p>“ Health, meeting new people I lost a stone and five pounds in weight...</p>
<p>Improved life skills and employability</p>	<p>Drink Wise, Age Well encouraged programme participants to try different activities, providing opportunities for constant learning of new skills and gaining confidence through this. As evidenced by qualitative data, a number of participants moved into volunteering as a result, which helped them develop their interpersonal and leadership skills, and improved their employability. For some this became a pathway into (re)entering the workforce:</p> <p>“ I'd got physically and mentally fitter and I'd been sober for a year or so. (...) I was volunteering [regularly] but I wanted to get back into paid work. (...) So that's what I did. (...) I wanted a job that was a bit more physical and when I'd done it at the end of the day I could walk away from it. So yeah, I'd applied for it and I got it.</p>

SUPPORTING PEOPLE TO MAKE CHANGES TO THEIR ALCOHOL USE PERFORMANCE NARRATIVE

Our logic model outlines what we would expect to see if Drink Wise, Age Well was 'supporting people to make changes to their use of alcohol'. We examined the evidence in relation to the nature of the support Drink Wise, Age Well provided and whether this helped to reduce hazardous or harmful use of alcohol.

In online and everyday public spaces like supermarkets, Drink Wise, Age Well staff talked to people about their use of alcohol. We Are With You, the lead partner for Drink Wise, Age Well has delivered an online webchat service via its website for over 2 years. In that time they have had 641 online chats. 38% said that it was the first time they had accessed support.

1,704 public stall events were held across the 5 areas over the programme life, and contact was made with 58,944 individuals. 60,000 leaflets or interactive materials (e.g. unit cups) were handed out, and advice was given to individuals more than 25,000 times. 6,575 alcohol brief interventions were conducted, 93% of them at public stalls. People were provided with information about safe drinking limits, where to get help if they thought they needed it and how Drink Wise, Age Well or other organisations could support them to reduce their use of alcohol. Whilst we cannot say how many of these people then went on to reduce their alcohol use or to tried to get help to do so, more than half (57%) of those who were drinking at hazardous or harmful levels said it was the first time they had been asked about their alcohol use and just less than half (43%) said they intended to make changes.

In total across the demonstration areas, over 5,800 referrals were received by the alcohol intervention service over the life of the Drink Wise, Age Well programme, 28%

of which were self-referrals. 3,400 people (87% of all referrals) presented with alcohol use as the main concern, of which 38% had not previously received any sort of alcohol intervention.

Initially, many of the people who were referred to the alcohol intervention service for support to make changes to their use of alcohol required clinical intervention with assisted medical detox. The ability of the staff to meet those needs was limited. Over time, however, the nature of the service on offer became better appreciated by those making referrals and the alcohol intervention service were able to support people to make changes in their alcohol use by providing a listening ear, encouraging and motivating people to change, helping programme participants (re)build social ties (engage in social activities) and/or to re(build) family/friendship ties. The support provided was also in accessing mainstream health services.

During this time, or once initial goals were achieved, programme participants could also access activities or groups that sought to develop resilience (see separate performance story). The range of interventions available could be tailored to the needs of those accessing the service. 78% of who reported that the location they typically drank alcohol was at home and alone, suggesting part of their needs related to widening their social networks.

There were reductions in terms of alcohol consumption and some health and social care use but none of these were statistically significant when compared with outcomes for people aged over 50 receiving a mixed-age service. In relation to individuals receiving the alcohol intervention service, and amongst those who completed pre and post intervention assessments, there were statistically significant improvements in levels of depression, anxiety and wellbeing.

Whilst efforts were directed at encouraging other harder to reach groups, like people from Black, Asian and other minority ethnic groups or LGBTQ+ communities, to access Drink Wise, Age Well services, this was not always successful. That said, the Drink Wise, Age Well service seemed to attract participants from a higher age bracket than a comparable mixed age service and these people reported that the Drink Wise, Age Well service was very different from the services they had experienced before. Programme participants talked of the service feeling less stigmatising and, compared to people aged over 50 attending a mixed-aged service, fewer people disengaged with the alcohol intervention service.

This latter finding is likely to be linked to how Drink Wise, Age Well services were delivered. Drink Wise, Age Well staff were mindful of the generational expectations of older adults which could limit their engagement with services (e.g. some older service participants can be more worried about asking for help and wary about self-disclosure) or which can act as barriers to living a fuller life.

Adjusting to loss was a key challenge for many programme participants. For those assessed by the alcohol intervention team for an alcohol problem, the top three reported triggers to increased drinking were bereavement (20%), relationship problems (20%) and loss of sense of purpose (16%). In response Drink Wise, Age Well staff sought to promote a positive sense of 'being older' and to help programme participants establish new social contacts and routines in their lives.

Older adults are more likely to reminisce to remind themselves of who they are (identity formation) or in addressing issues of loss. Some experience failing capacities and some may have been drinking problematically for a long time. Staff perceived that for these individuals change may be more difficult than for younger people. So alcohol intervention service staff spent more time with programme participants, and undertook more home visits than most mixed-age service providers reported being able to do.

Family support or mutual aid/peer support groups were established in some areas. To this end, Drink Wise, Age Well staff were trained in the 5 Step Method.¹² 2,600 mutual aid/peer support group sessions for people with alcohol problems were facilitated and 1,096 people attended them. These groups were a key part of Drink Wise, Age Well activities in many areas but proved difficult to organise and sustain in others, for example because of geography. Services were therefore adapted and very often family support was more informal e.g. giving a family member harm reduction advice in the home, or supporting a family member over the phone.

CONCLUSION

We found evidence to support the conclusion that our logic model played out as expected and therefore that Drink Wise, Age Well supported people to make changes to their alcohol use. Accordingly the 'performance story' we outline is of an age appropriate programme response to the harms associated with alcohol.

The Drink Wise, Age Well service was based on the understanding that to make changes to their use of alcohol, people aged 50 and over needed information to see that a change was necessary and then the support around them to put change into effect.

Drink Wise, Age Well was successful in providing large numbers of people with information about hazardous and harmful use of alcohol and, at least in the immediate term, getting people who had not been previously been asked, to benchmark their use of alcohol against recommended alcohol guidelines. As there is evidence that delivering alcohol brief interventions can improve public health outcomes, it is likely this activity contributed to reducing the harms associated with alcohol amongst older adults in the demonstration areas.

Older drinkers can benefit from intervention as much as younger drinkers. Qualitative and quantitative data suggest there was equivalence in terms of outcomes between the alcohol intervention service and what might be achieved in other services. A large proportion of people engaging with the alcohol intervention service were self-referrals and the service appeared to appeal to an older demographic. Programme participants talked about the alcohol intervention service being different (less stigmatising and more flexible) and they were less likely to disengage from the service than a comparable mixed age service.

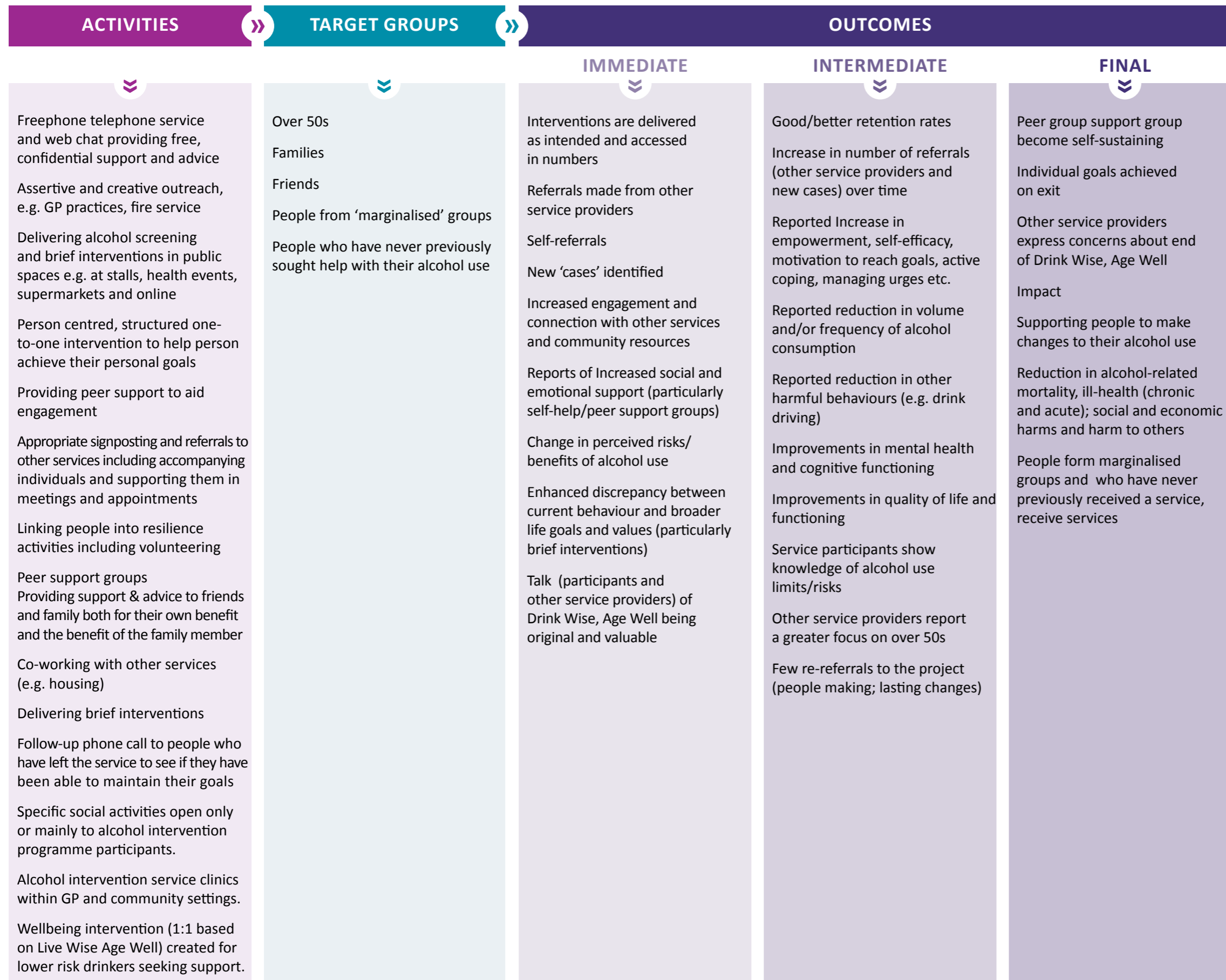
It is possible to conclude therefore that the 'headline' performance story of Drink Wise, Age Well in relation to supporting people to make changes to their alcohol use in the demonstration areas is:

Drink Wise, Age Well supported adults over 50, many of whom might not otherwise have seen the need or received a service to make changes to their alcohol use.



¹² <https://www.afinetwork.info/5-step-method>

LOGIC MODEL: SUPPORTING PEOPLE



TESTING THE ASSUMPTIONS

We consulted research literature to explore whether the logic behind the key areas of activity was appropriate, including examining the basis of any theoretical assumptions made. The assumptions we considered were:

- Are alcohol problems less likely to be identified in older adults?
- Do frontline service providers lack skills in identifying and responding to alcohol problems in older adults?
- Does the involvement of family members lead to better outcomes for both the older adult and the family member themselves?
- Are alcohol brief interventions and peer support groups effective for older adults with alcohol problems?
- Do age-specific alcohol services have better outcomes compared to mixed-age services and are more acceptable to some adults?

Are alcohol problems less likely to be identified in older adults?

The World Health Organisation has identified alcohol-related harm among older adults as an increasing concern,^[21] but problems among older adults remain a ‘hidden’ problem and are often under diagnosed.

Despite a World Health Organisation recommendation that all primary care patients should be asked about their alcohol use,^[77] evidence suggests that this is less likely to occur among older adults. Research suggests that GPs find it difficult or are reluctant to ask questions about alcohol use among older adults^[78-79] and are less likely to request an alcohol use history from older adults.^[80] This may help to explain the finding that the prevalence of alcohol use disorders among older adults is underestimated by many GPs^[81] and GPs often fail to identify hazardous alcohol use among older patients.^[82] Data suggests that GPs may not enquire about an older person’s use of alcohol for a number of reasons, such as a reluctance to ask what they perceive as embarrassing questions of older adults, lack of awareness of alcohol being a problem for older adults, and ageist beliefs that older adults are too old to change their behaviour and are less likely to benefit from treatment.^[18, 83]

Conversely, there is some evidence to suggest that the rate of detection among older adults may actually be better among older adults than among younger age groups.^[84] In a study which compared the observed rates of alcohol use disorder in general practice with the expected rates, there was a better rate of detection among those aged 55-64 years than those aged 16-24 years. However, this study only included people up until the age of 65 years, and the AUDIT was used to screen for hazardous use which may be less appropriate for use among older adults.^[85]

Evidence suggests older adults are less likely to recognise the signs of dependence and do not understand alcohol units.^[61, 86] They are also the least likely to know about the risks relating to alcohol use^[86] and may feel stigma in relation to their alcohol use.^[18] Therefore, older adults may be less likely to seek help. This is compounded by the fact that GPs are uncomfortable bringing up issues that are not on the patient’s agenda.^[87]

Furthermore, age-related changes in lifestyle, such as retirement and reduced social network, can mean that there is less opportunity for others to notice any signs of increased drinking. Research also shows that older adults typically drink alone at home,^[88] making detection more difficult for friends and family.

In addition, the signs of hazardous alcohol use or alcohol dependence can be difficult to distinguish from conditions associated with ageing or may be misattributed with the side effects of prescribed or over the counter medications. Alcohol problems also occur at lower levels of drinking in older adults, so the amount consumed is not a reliable measure of hazardous drinking. This may help to explain the poor rates of detection in primary care settings found in previous research. In England, older adults are more likely to be admitted to hospital for an alcohol related condition than younger people, but they frequently go undetected.^[46] Earlier studies support this assertion; a study in the Netherlands found alcohol use was only noted in the medical records of 33% of older adults with alcohol problems,^[89] an Australian study found only a third of older problem drinkers were identified by hospital medical staff,^[90] and an American study found only 37% of older drinkers were identified.^[91] More recently, in an acute inpatient geriatric inpatient setting with high levels of alcohol use disorders, only very few people were asked about their use of alcohol.^[92]

Screening and assessment of alcohol use in older adults requires appropriate knowledge and skills relevant to ageing; there needs to be consideration of atypical presentation, co-morbid health conditions and a greater emphasis on social and physical aspects of assessment compared to younger people. In the Drink Wise, Age Well survey, amongst those people who reported that they were drinking more now than in the past, the five most frequently reported reasons for the increase are age-related. These were retirement (40%), bereavement (26%), loss of sense of purpose in life (20%), fewer opportunities to socialise (18%) and a change in financial circumstances (18%).^[61]

Effective assessment also needs to take into consideration the fact that many clinical measures designed to screen for alcohol use problems may be inappropriate for use among older adults. Indeed, it could even be argued that the first two criteria of the DSM-IV definition of alcohol abuse are more applicable to younger and not older adults (e.g. ‘failure to fulfil obligations at work, school or home’, ‘using alcohol in situations in which it is physically hazardous’). Most screening tools designed to identify hazardous, harmful or dependent alcohol use have been developed for use among younger people and may not be validated for use among older adults. Research found early iterations of the AUDIT to have low sensitivity in detecting alcohol use in older adults.^[85] The Michigan Alcohol Screening Test (MAST) included many questions developed for younger adults and focused on personal feelings and consequences that have less relevance for older adults. As a result, the older person’s version of the MAST, the MAST-G has been developed and focuses on problems associated with drinking in older adults. The MAST-G has been found to reach acceptable levels of sensitivity if the cut-off is decreased from five to three, although there is then a drop in specificity.^[85]

The CAGE (‘Cut-down, ‘Annoyed’ ‘Guilty’ and ‘Eye-opener’) is thought to be appropriate for use in older adults if the cut-score is decreased from two to one,^[85] although there are still questions regarding its appropriateness due to a focus on consequences that are less relevant to older drinkers.^[18, 93]

Evidence suggests that alcohol problems are less likely to be identified in older adults. There are a number of reasons for this: ageism, a lack of knowledge and a reluctance of healthcare staff to ask older adults about their use of alcohol; difficulty in distinguishing signs of dependence from other health conditions; the appropriateness of screening tool designed to identify hazardous or harmful alcohol use; limited knowledge among older adults regarding drinking guidelines and alcohol risks; and a reluctance among older adults to seek help due to feelings of shame and stigma. When asked about attitudes towards people with alcohol problems, 20% of respondents in a Drink Wise, Age Well survey thought that the majority of people with alcohol problems cannot recover, and 45% thought that people with alcohol problems have themselves to blame (increasing to 55% for over 65s). These attitudes, held by a significant minority of older respondents in the UK indicate that there are some stigma and barriers which need to be considered when forming strategies to reduce alcohol-related harm in this age group.^[61]

Do alcohol workers in mixed-age services lack skills in working with older adults?

The use of alcohol among older adults is increasing,^[94-96] and in line with this, so is the demand for treatment.^[97-98] Research suggests that substance use services designed for older adults may be more acceptable to older adults than mixed-aged services^[18] and may be linked to better outcomes than mixed-age services.^[12-16, 99] This leads us to question ‘Do alcohol workers in mixed-age services lack skills in working with older adults?’

Age-specific alcohol services for older adults are specifically designed to meet the needs of older adults. This should include the use of age-sensitive assessments, screening for cognitive impairment, interventions adapted to the needs of older adults (e.g. focused on life stage issues), home visits, providing longer sessions, greater collaboration and links with other health and social care systems, and age-specific peer support groups. Staff also need to be knowledgeable about the potential effects of alcohol as we age, such as poor sleep, cognitive impairment and potential interactions with prescribed medications.

Whilst staff in mixed-aged services may have some of the necessary skills to do this, the competing pressures of working within mixed-aged services may mean that older adults are overlooked. Alcohol workers in mixed-aged services often have larger caseloads than staff within services specifically designed for older adults, meaning staff have less time to spend with participants, and sessions are shorter compared to older adult services. Many services are also unable to offer home visits,^[44] meaning that in many cases older adults with mobility issues simply cannot access treatment for alcohol use.

It could also be argued that staff working within mixed-age services may not have the necessary expertise or resources to individually tailor treatment for older adults. For example, evidence suggests treatment services have difficulty in meeting the needs of older adults with cognitive impairment associated with alcohol misuse.^[100] Although with training and on-going clinical support, staff within mixed-age services could be trained to work with older adults in an age-sensitive way.

Alcohol services have traditionally focused on the needs of younger adults.^[44] This is hardly surprising given that the National Institute of Health and Clinical Excellence (NICE) which issues guidance on the treatment of drug and alcohol misuse do not give specific consideration to older adults. In fact, the studies on which NICE base their recommendations typically exclude people over the age of 65.^[101] Older adults also rarely given specific consideration in drug and alcohol policy,^[44] meaning the needs of older adults remain unidentified and older adults not catered for.

Nevertheless, there is some evidence to suggest that older adults do just as well as their younger counterparts in mixed aged services,^[102-103] suggesting that staff may have the skills to work with older adults effectively. As concluded in a recent report by the Royal College of Psychiatrists “age specific treatment may potentiate treatment, possibly due to greater levels of engagement or retention in treatment, but it does appear that older people can respond to treatments that have been developed and tested in younger populations”.^[101, p.78]

Older adults frequently have contact with a wide range of health and social care practitioners who are well placed to identify alcohol use problems. However, those working in statutory and voluntary services that frequently encounter older adults rarely receive training in alcohol use, and research suggests that frontline service providers are not routinely screening for alcohol use problems or even asking about the use of alcohol among older adults. This means that opportunities for intervention are being missed.

A survey of social work and social care practitioners who work with older adults found 41% rarely asked older adults about their alcohol use, and 38% reported difficulty in identifying the signs of drug or alcohol dependence in older adults.^[104] Furthermore, social care professionals who work with older adults are less likely to ask about substance use compared to those working with younger people.^[42] Training for social care professionals on drug and alcohol use is often targeted to those working in Children’s rather than Adult Social Care,^[46] and it is acknowledged that health and social service professionals lack adequate knowledge about the signs, symptoms and consequences of problem drinking, especially among older adults.^[105]

The assessment of alcohol use is also rarely considered in care homes for older adults. In a study of 111 care home facilities in America, it was found that only 58% took an alcohol use history at admission, and the information collected varied dramatically between institutions.^[106] There is also reason to suspect that older adults may underreport any past alcohol use problems, as some of the care homes surveyed reported that an individual with a history of alcohol related problems may be refused admission. In addition, this study revealed that staff within 75% of care homes had not received any training in relation to alcohol, with only a few members of staff trained within the remaining facilities.^[106]

A reluctance to ask older adults about their use of alcohol is in line with some of the early findings of Drink Wise, Age Well. Our own research has revealed that of a survey of almost 17,000 older adults, 80% of those classed as increasing risk drinkers had never had concerns about their drinking raised by family members, friends or health professionals.^[61]

Even when alcohol use is identified as a problem, older adults are less likely to have alcohol treatment recommended by physicians or to initiate it when it is recommended.^[91,107] Instead, older adults are more likely to receive medical management of health problems associated with the use of alcohol, rather than to receive treatment for the alcohol problem.^[108] Indeed, our own work demonstrates that older adults may be referred to generic services, such as a care home, as a result of their alcohol problem, rather than to alcohol specific services.^[44]

One potential reason for the lack of referral to specialist alcohol treatment may be a reluctance to intrude on the person’s right to privacy, as was found in an earlier study with outreach workers.^[109] Research also suggests that frontline workers, such as social workers find it difficult to balance the ‘right’ of older adults with alcohol problems to continue to drink against the ‘risk’ associated with them doing so.^[46]



Does involvement of family members lead to better outcomes for both the older adult and the family member themselves?

The 'typical' nuclear family of parents, children and possibly grand-parents living under one roof, is now just part of a far more wide-reaching version of family that exists in the UK. These may include, traditional, single-parent, extended, adoptive and step families.^[110]

Flynn^[111] suggests that although research indicates inter-couple and family therapy can be effective in the treatment of hazardous or harmful alcohol use, local alcohol treatment services are increasingly reluctant to provide and support these services. Also, the lack of funds for alcohol treatment services has meant the NHS has prioritised treatments involving only the individual with an alcohol problem. This situation has occurred even though there is a sound evidence base of family therapy and interventions having successful outcomes, not only for the client, but for their family who also may have been suffering stress, illness and financial problems due to the behaviour of a family member.^[111, 112] One consequence of the drinker-focused criteria has led, at times, to other family members' needs being hidden. Indeed, it is estimated that 1.4 million adults are affected by the substance misuse of relatives and that these harms may cost the economy £1.8 billion per year.^[113]

These adults not only need to manage their own needs within the family dynamic, but also be able to offer support to the substance-using relative and wider family members.^[113]

The Copello and Templeton report for the Drug Policy Commission also found a welcome realisation of the effect substance use has on the wider family including some examples of good practice. Conversely they found a lack of consideration for the effect on adult family members as well as a lack of detail of how to support these adults. In its conclusion the report believes there has to be more promotion of what is needed and what works, improving assessments and identifying 'hidden' groups of adults. These plans must also include the various sub-groups of adult family members.

In conclusion, alcohol problems often affects the wider family and friends. Part of successful therapy includes strengthening these relationships, as family members can be a 'powerful force for change,' help in successful outcomes and heal the damage that alcohol problems have wrought in their lives.^[114] That being stated, involving family members in treatment can be challenging as relationship breakdown is a feature of longer term problematic alcohol use.

Are alcohol brief interventions and peer support groups effective for people with alcohol problems?

Existing literature suggests provision of 'brief interventions' in relation to alcohol use, especially in health care setting can impact positively on public health. This conclusion applies in terms of reducing alcohol consumption among those drinking at hazardous and harmful levels.^[112, 115]

Humphreys^[116] has identified some of the shared characteristics of different mutual aid groups. These include: members sharing or identifying with a problem that causes them distress or suffering; group members offering and receiving support; and groups facilitated by fellow group members.

It is important for healthcare professionals to understand the importance of linking individuals and families to mutual aid groups that echo their own philosophy. Evidence points to the fact that when there is a match of philosophies within a support group the support group participation improves, as do the recovery outcomes. There appears to be a correlation between a support group member, their sense of belonging, underlying worldview (religious, scientific) and their recovery.^[117] Research has also found that the more stigmatising a problem (HIV, alcoholism, drug addiction) the stronger the search for a support group, whether physical or internet based.^[118]

Do age-specific alcohol services have better outcomes compared to mixed-age services and are more acceptable to some people?

Crome and Crome^[119] suggest that in relation to older adults who are engaged in harmful or hazardous use of alcohol... **"There is a massive gap in the whole gamut of research from basic to clinical research in this vulnerable patient population: this has to be developed if management is to be effective and up to date."**

The implication of a gap in research and knowledge is likely to become more significant as the 'baby boomer' generation, born in the 1960s, enter old age.^[101] At present, however, one implication is that it is not definitively proven that age-specific or mixed-age services provide for better for long-term outcomes.^[101] That older adults with alcohol problems wish to engage with and can benefit from interventions is widely accepted.^[120] Crome and Crome^[119] suggest older adults have been shown to respond well to programmes developed for a younger population. Lemke and Moose^[121] consider that older adults do just as well as their younger counterparts when undergoing therapy for alcohol problems. The authors suggest that the inequalities faced by older adults within mixed-age therapy

are not profound and people from across the ages respond to a "cohesive and emotionally supportive treatment environment." However both Crome and Crome^[119] and the British Medical Council^[122] argue that the possibility exists that that this group could achieve even better outcomes in an age-specific programme. Older adults are excluded from services as a result of ageism and direct and indirect discrimination.^[44, 123] Rao^[124] has explored practice with older adults with alcohol problems and argued that barriers to services exist and that to overcome them an 'age-sensitive' approach to assessment and then treatment of older adults with alcohol problems was necessary. In addition, he suggested staff be given more specific training in identifying and responding to the needs of older drinkers. This training should be focussed on: working at a slower pace whilst encouraging self-esteem; adopting a non-confrontational approach to support the older adult through life stage transitions around grief, loss, and impaired physicality.^[119] In the UK Wadd et al^[18] found evidence of only five substance misuse agencies containing an older adults' service. None of these services had been rigorously evaluated.



EVIDENCE IN RELATION TO THE LOGIC MODEL

IMMEDIATE OUTCOMES	
OUTCOME	EVIDENCE SUMMARY
Interventions are delivered as intended and accessed in numbers	Reports drawing on a range of statistical data indicate that identified interventions were delivered at scale over the five year life span of the Drink Wise, Age Well programme. Interventions varied in dosage from information giving (online and leaflets); advice giving, alcohol brief interventions, workshops, to support via the alcohol intervention service. Peer support groups and family support groups were difficult to establish, however, in some areas.
Referrals made from other service providers	Individuals were frequently referred by other agencies as part of an ongoing treatment package. Analysis of alcohol intervention service referrals at the mid-point of the project indicated that there were some established and consistent referrers into the service and a wide range of other organisations making a low quantity of periodic referrals and a steady increase in self-referral over time. Closer working with service partners increased the number of appropriate referrals into the alcohol intervention service over time. Over 5,800 referrals were received by the alcohol intervention service over the programme life. 33% of these were received from substance misuse services – statutory and non-statutory (17% and 16% respectively). In terms of assessments on people whose presenting problem as alcohol related, the number of assessments completed increased over the life of the programme: (year 1-5: 360, 580, 788, 932, 752).
Self-referrals	Over 13,500 expression of interest contacts were made across the 5 areas over the programme life. Of these the largest proportion was self-referrals (56%), followed by referrals made by professionals (36%). In relation to the alcohol intervention service, of all referrals – 28% were self-referrals.
New 'cases' identified	<p>Programme participants in Drink Wise, Age Well services were from a higher age group than in a comparable service indicating individuals were being drawn into the service that might otherwise have been missed. 38% of alcohol intervention service programme participants had not received alcohol treatment previously.</p> <p>57% of people who had a positive AUDIT-C score, indicated they had not been asked questions about their alcohol use before.</p> <p>In relation to most interventions the overwhelming majority of participants were white/heterosexual e.g. in relation to the alcohol intervention service of those who disclosed their ethnicity group 98.3% were White and only 2.6% identified as LGBT. That said, multiple workshops were delivered with intermediary organisations e.g. Auditory Impairment, BAME, Carers, Chinese community, Deaf community, Dementia, Elderly Care, Gypsy & travellers, LGBTQ+, Mental Health Organisations, Physical Disabilities, Polish community, Prisoners, Roma Community, Sensory loss, Specialist ethnic support service, Visually impaired, Women, Zimbabwean nationals.</p>

IMMEDIATE OUTCOMES	
OUTCOME	EVIDENCE SUMMARY
Increased engagement and connection with other services and community resources	Process focused reports and monitoring data, as well as qualitative data indicates that the Drink Wise, Age Well service became embedded in the local service landscape(s) over time. Of those that reported how they heard about Drink Wise, Age Well 39% said it was from other services, 27% from Drink Wise, Age Well services, and 17% via word of mouth. Drink Wise, Age Well staff became increasingly aware of referral pathways in their local areas e.g. to existing community groups/sources of support. Available reports suggest programme participants found social activities not only expanded their social network and interests but also normalised their social relationships
Reports of increased social and emotional support (particularly self-help/peer groups)	More than 2,600 peer support group sessions for people with alcohol problems were facilitated and 1,096 people attended them. Where they existed, self-help/peers support groups were well received, but in some areas were difficult to establish e.g. Wales because of geography. There was evidence from research interviews that people attending the sessions had an increased sense of mutuality and hope.
Change in perceived risks/benefits of alcohol	Advice was given to 25,000 people at public stall events but it is not clear how this influenced perceptions. 6,575 individuals were subject to an alcohol brief intervention involving completion of the AUDIT-C and a FRAMES based conversation. 43% of these said they would make changes following that activity (see also workshop data below). Most programme participants reported that involvement in the alcohol intervention service increased their knowledge about alcohol-related harm (and understanding their own personal risk) and it helped to reduce and/or control their consumption.
Enhanced discrepancy between current behaviour and broader life goals and values (particularly brief interventions)	6,575 people received screening and brief intervention face-to-face and 9,951 online (using the Drink Wise, Age Well Drink Checker). 74% of women and 77% of men who received screening and brief intervention face-to-face had a positive score. 43% said they intended to make changes to their drinking.
Talk (participants and other service providers) of Drink Wise, Age Well being useful and original	There was evidence that Drink Wise, Age Well engaged with people who would not otherwise have received a service. Many programme participants had not previously received a service. Drink Wise, Age Well staff and programme participants, including professionals in the demonstration areas were positive about the 'added value' the Drink Wise, Age Well provided to programme participants.

INTERMEDIATE OUTCOMES

OUTCOME	EVIDENCE SUMMARY
Good/better retention rates compared to mainstream services	Drink Wise, Age Well programme participants were less likely to drop out of service than adults aged 50 and over attending mixed age services. People were significantly less likely to disengage from the Drink Wise, Age Well alcohol intervention service (3%) than people aged over 50 attending the mixed-age services (10%). Those involved with Drink Wise, Age Well often referred to it being less stigmatising and more welcoming. We were not able to follow up with those who had left the service earlier or decline a service.
Increase in number of referrals (other service providers and new cases) over time	Alcohol intervention service referrals increased over time from 627 in year 1 (2015-2016) to 1577 and 1252 in year 4 and 5 respectively (2018-2019/ 2019-2020).
Reported Increase in empowerment, self-efficacy, motivation to reach goals, active coping, managing urges etc.	Drink Wise, Age Well programme participants reported positive outcomes from involvement with the programme and there were many examples of programme participants taking on 'advocacy' related roles during the lifetime of the programme. In relation to people who attended family support groups, on average there was a 50% reduction in "family burden" which is a measure of a combination of the negative impact of the problem, the family member's physical and psychological well-being, and styles of coping commonly associated with increased stress and strain.
Reported reduction in volume and/or frequency of alcohol consumption	In relation to relevant services, qualitative research indicates engagement with Drink Wise, Age Well was associated with reductions in alcohol use. Statistical data suggests at the time of referral for alcohol problems, 80% of programme participants were drinking above the weekly guidance, 14% were not drinking at the time of initial assessment. Of those who completed discharge assessment, 48% were drinking above weekly guidance, 30% were not drinking at the time of discharge. Of those who completed 6 month follow-up assessment, 47% were drinking above weekly guidance and 28% were not drinking at the time of follow-up.

INTERMEDIATE OUTCOMES

OUTCOME	EVIDENCE SUMMARY
Reported reduction in other risky behaviours (e.g. drink driving)	Hospital admission data was difficult to access and interpret. A planned quasi-experimental study which involved a 'before' (pre-test) and 'after' (post-test) survey of people living in the intervention and matched control areas had to be abandoned because of restrictions imposed to control the Covid-19 pandemic.
Improvements in mental health and cognitive functioning	Qualitative data and pre- and post-intervention improvement on a range of measures.
Improvements in quality of life and functioning	Qualitative data and pre- and post-intervention improvement on a range of measures.
Programme participants show knowledge of alcohol use limits/risks	Qualitative data and pre- and post-intervention improvement in a range of measures. Questions were asked at the start and end of the workshop to monitor learning. 92% and 93% of over 4,000 respondents respectively agreed with the statement 'My understanding and knowledge of alcohol has improved since attending the workshop' or I would know where to get help should me or my family need it'. Those attending workshops were asked if they knew the current UK government drinking guidelines. 68% changed from no to yes following the workshop.
Other service providers report a greater focus on adults over 50	Reports reflect on engagement by Drink Wise, Age Well with a wide range of professionals. In workshop settings there is evidence (see above) of greater awareness of issues related to use of alcohol by older adults.
Few re-referrals to the project (people making lasting changes)	No data.

FINAL OUTCOMES

OUTCOME	EVIDENCE SUMMARY
Mutual aid/peer support groups become self-sustaining	Self-help/peers support groups have had a varied level of success across the demonstration areas. Where they existed they were well received but in some areas were difficult to establish e.g. Wales because of geography. Only some evidence/accounts of groups becoming self-sustaining.
Goals achieved on exit	<p>76% had decreased their alcohol consumption at discharge and 57% were drinking within the recommended weekly guidelines at discharge. 97% remained until the end of treatment.</p> <p>Of note were home visits that often resulted in alcohol intervention service key workers accompanying programme participants to the local alcohol treatment/rehab services with the aim of facilitating more intense treatment, or providing advocacy and practical help to encourage engagement with these services. This was extremely important since many programme participants would not/could not attend mixed age alcohol services due to mobility, lack of transport, physical and mental health problems and the fear/stigma of attending an 'alcohol service'.</p>
Other service providers express concerns about end of Drink Wise, Age Well	No data as the onset of covid-19 compromised ability to conduct interviews.
Impact Supporting people to make changes to their alcohol use	<p>In relation to those who were referred to the alcohol intervention service with a presenting problem of alcohol only, (88% of referrals) 80% of participants were drinking above the weekly guidance, 14% were not drinking at the time of initial assessment. Of those who completed discharge assessment, 48% were drinking above weekly guidance, 30% were not drinking at the time of discharge. Of those who completed follow-up assessment, 47% were drinking above weekly guidance, 28% were not drinking at the time of follow-up.</p> <p>Of those who completed the peer support snapshot survey, 48% stated that they have stopped alcohol use since they started attending peer support groups, 40% had reduced alcohol use.</p>

FINAL OUTCOMES

OUTCOME	EVIDENCE SUMMARY
Reduction in alcohol-related mortality, ill-health (chronic and acute) social and economic harm and harm to others	<p>The Short Warwick Edinburgh Mental Wellbeing Scale (SWEMWBS) was used to measure mental wellbeing. Higher scores indicate higher positive mental wellbeing. For alcohol intervention service participants the average S-WEMWBS increased between initial assessment and discharge from 19.67 to 24.18. At follow up the average score was 24.5. Between assessment and discharge 74% of people attending the alcohol intervention service had an increase in wellbeing (47% at six month follow up).</p> <p>The Patient Health Questionnaire -9 (PHQ-9) is used for measuring severity of depression. Lower scores indicate lower states of depression. Average scores of PHQ-9 between initial assessment and discharge lowered from 13 to 7. At follow up they had lowered again to 6. Between assessment and discharge 44% had a reduction in depression scores.</p> <p>General Anxiety Disorder scale (GAD-7) – a seven question scale used to monitor signs of anxiety. Lower scores indicate lower states of anxiety. Average scores of GAD-7 between initial assessment and discharge lowered from 10 to 6. At follow up they had lowered again to 5. Between assessment and discharge 45% had a reduction in scores for anxiety.</p> <p>The Montreal Cognitive Assessment (MoCA) is designed to help identify symptoms of cognitive impairment. Lower are indicative of greater impairment. Of those who completed the MoCA screening tool at assessment 48% scored in the mild, moderate or severe categories – which are indicative of a cognitive impairment. Of those who completed the MoCA screening tool at discharge 30% scored in the mild, moderate or severe categories – which are indicative of a cognitive impairment.</p> <p>Deaths related to alcohol and hospital admission data was accessed pre and post Drink Wise, Age Well in one demonstration area but the data was inconclusive and difficult to analyse.</p> <p>Half of those entering the alcohol intervention service had used health or social care services because of alcohol in last 12 months, at 6 month follow-up this has fallen to 16%</p> <p>There was a 34% reduction in number of people reporting falls or accidents at 6 month follow up.</p>
People from marginalised groups and who have never previously received a service, receive services	The evidence in relation to the programme appealing to demographics that are traditionally excluded from mainstream services is less clear. Only 2.6% of individuals presenting to the alcohol intervention service identified as LGBT. 98.3% were White.

REDUCING STIGMA AND DISCRIMINATION

PERFORMANCE NARRATIVE

Tackling alcohol-related stigma and discrimination is vital to improving the lives of older adults with alcohol problems and key to reducing harm from alcohol. Stigma arises from projecting negative beliefs about a group of people (stereotypes) and showing prejudice (displaying negative attitudes) or discrimination (negative behaviour) towards them. There are many different types of stigma but some are particularly relevant in terms of people who have alcohol problems:

PUBLIC STIGMA	Public stigma is the reactions of the general public towards people with alcohol problems, based on stigmatising attitudes about problematic alcohol use.
PROFESSIONAL STIGMA	Professional stigma is the negative beliefs, attitudes and behaviours of professionals towards people with alcohol problems.
SELF-STIGMA	Self-stigma (also known as felt stigma) is when people with alcohol problems internalise negative public attitudes and accept them as valid.
STIGMA THROUGH ASSOCIATION	Stigma through association is the experience of being stigmatised as a consequence of association, for example being a family member of a person with an alcohol problem.
STRUCTURAL STIGMA	Structural stigma occurs when institutions intentionally or unintentionally create policies, procedures, or practices that disadvantage those with alcohol problems.

Stereotyping, prejudicial, judgemental and stigmatising views of people with alcohol problems are common. For example, a stereotype of people with alcohol problems is that they are weak-willed or lacking resolve. However, even with considerable willpower and determination it can be very difficult for someone with an alcohol problem to control their drinking. Older adults may be subject to additional stigma because of their age, resulting in overlapping layers of discrimination. A stereotype of older adults with alcohol problems is that they are set in their ways, therefore too old to change. This may mean they are not referred for alcohol treatment. In reality, older adults are more likely to be successfully treated for an alcohol problem than people in other age groups.

Stigma and discrimination occur across a range of settings including health and social care, employment and housing as well as in relationships with family and friends and in the general community. People are often afraid to disclose their alcohol problem (past or present) for fear of losing their jobs or not being hired in the first place, being refused housing or being treated less favourably in health and social services. Fear of stigma and discrimination can prevent people seeking social support, help or treatment for their alcohol problem. It can lead to feelings of shame, anger, hopelessness and despair and contribute to poor mental and physical health.

Drink Wise, Age Well was not a stigma-reduction programme but reducing stigma was one of the programme's objectives. Only a small number of the activities were designed specifically to reduce stigma but stigma reduction was a common thread running through the activities.



Has Drink Wise, Age Well reduced public and professional stigma?

Drink Wise, Age Well used a variety of approaches to reduce public and professional stigma. To normalise discussion about alcohol use, improve knowledge and reduce stigmatising attitudes and ageist stereotypes, staff had conversations with 58,944 members of the public at public stalls and alcohol awareness workshops and training was delivered to almost 29,000 older adults and professionals. Professionals came from more than 150 organisations such as the police, the fire and rescue service, Citizens Advice Bureau, the NHS, trade unions and care homes. The majority of people who attended the training said their knowledge increased. Some said the training had challenged stereotypes they held of people with alcohol problems and people talked more openly about their own alcohol use as a result. Most professionals said they intended to make changes to their practice. One of the most common changes they said they would make was to have more conversations with older adults about their alcohol use.

Drink Wise, Age Well targeted the general public in a UK-wide social media campaign to reduce stigmatising attitudes, provide accurate information and increase support and sympathy for older adults with alcohol problems. The campaign reached over a million people and 83% of people who saw the campaign were more likely to believe that society should treat older adults with alcohol problems with a tolerant attitude. Members of the public often have little meaningful contact with people who have personal experience of alcohol problems. Drink Wise, Age Well created opportunities for people to come together with older adults with alcohol problems, for example, by taking part in training and social activities together. This is important because evidence from the mental health field suggests that personal contact can reduce prejudices and replace assumptions with mutual understanding and respect. However, people with alcohol problems rarely talked about their alcohol problems during the Drink Wise, Age Well activities. This may explain why there was no evidence that these interactions changed the way that people thought about older adults with alcohol problems.



Has Drink Wise, Age Well reduced self-stigma?

To reduce self-stigma, Drink Wise, Age Well challenged peoples' negative beliefs and perceptions about themselves and helped them to cope with experiences of stigma and discrimination through support and talking therapy. Other relevant activities included social activities (people with alcohol problems often avoid close contact with others to avoid being judged), resilience activities (so that people are better able to cope with stigma), peer support (to foster mutual understanding and hope) and opportunities for volunteering (to increase self-esteem and self-worth).

A considerable number of people with alcohol problems said they had more self-esteem and experienced less shame and self-blame as a result of these activities. Many found a new sense of purpose and found they thought less about their alcohol problem as a result of the social activities or volunteering. People could choose to see their key worker in their own home or

have contact with an alcohol professional through the anonymous webchat service. This may have helped some who feared the stigma of attending an alcohol service to get help. Some people said that Drink Wise, Age Well was less "judgemental" than other alcohol services and this could partly explain why programme participants were less likely to discontinue (disengage from) Drink Wise, Age Well services than older adults attending other alcohol services.

The majority of people who took part in the social activities said it had helped them feel better in themselves. Some felt that because the social activities were not specifically about alcohol or for people with alcohol problems, they were less stigmatising than interventions which focus on alcohol and they helped them to develop an identity beyond a person with an alcohol problem. People found that having contact with those who had recovered from an alcohol problem in peer support groups gave them hope.

Has Drink Wise, Age Well reduced stigma through association?

Families affected by alcohol problems frequently report that stigma has personally affected them. Stigmatisation within families can damage relationships, further side-line the person experiencing an alcohol problem and reduce the remaining social support. Drink Wise, Age Well provided one-to-one and peer support groups for families.

We weren't able to identify any evidence that family members experienced less shame, self-blame or low self-worth as a result of Drink Wise, Age Well. This may have been because stigma-reduction was not a clear goal for the work with families. There was some evidence that Drink Wise, Age Well gave family members a sense of hope.

Has Drink Wise, Age Well reduced structural stigma?

Drink Wise, Age Well established advocacy groups (known as Calling Time for Change Groups) in England, Scotland, Wales and Northern Ireland. The groups brought together people with lived experience of alcohol problems to influence policy. It is very important that the voices of people with lived experience of alcohol problems are heard in policy discussions about issues that affect their lives.

The Calling Time for Change groups brought about a number of policy changes. For example, Drink Wise, Age Well's Calling Time for Change study reported that some alcohol services did not meet the needs of older adults. One of the Charter for Change Groups met with the local commissioner of alcohol services and as a result, organisations now have to describe how they will address the needs of older adults when bidding to provide a service. Drink Wise, Age Well has recently developed an audit tool for alcohol services so that they can evaluate whether their services are sensitive to the needs of older adults.

Also as a result of the Calling Time for Change report, Public Health England were persuaded to prevent residential alcohol services setting upper-age limits on its online directory of services. The Calling Time for Change report was cited by:-

- The Scottish Government to make a case that older adults should be a priority group in terms of reducing alcohol harm.
- The Drugs, Alcohol and Justice Cross-Party Parliamentary Group and All-Party Parliamentary Group on Alcohol Harm to remind alcohol services of their duty to address the needs of older adults.
- Alcohol Change UK to call for an end to age discrimination in alcohol treatment services.
- The Royal College of Psychiatrists to draw attention to the scarcity of alcohol treatment services for older adults.

CONCLUSION

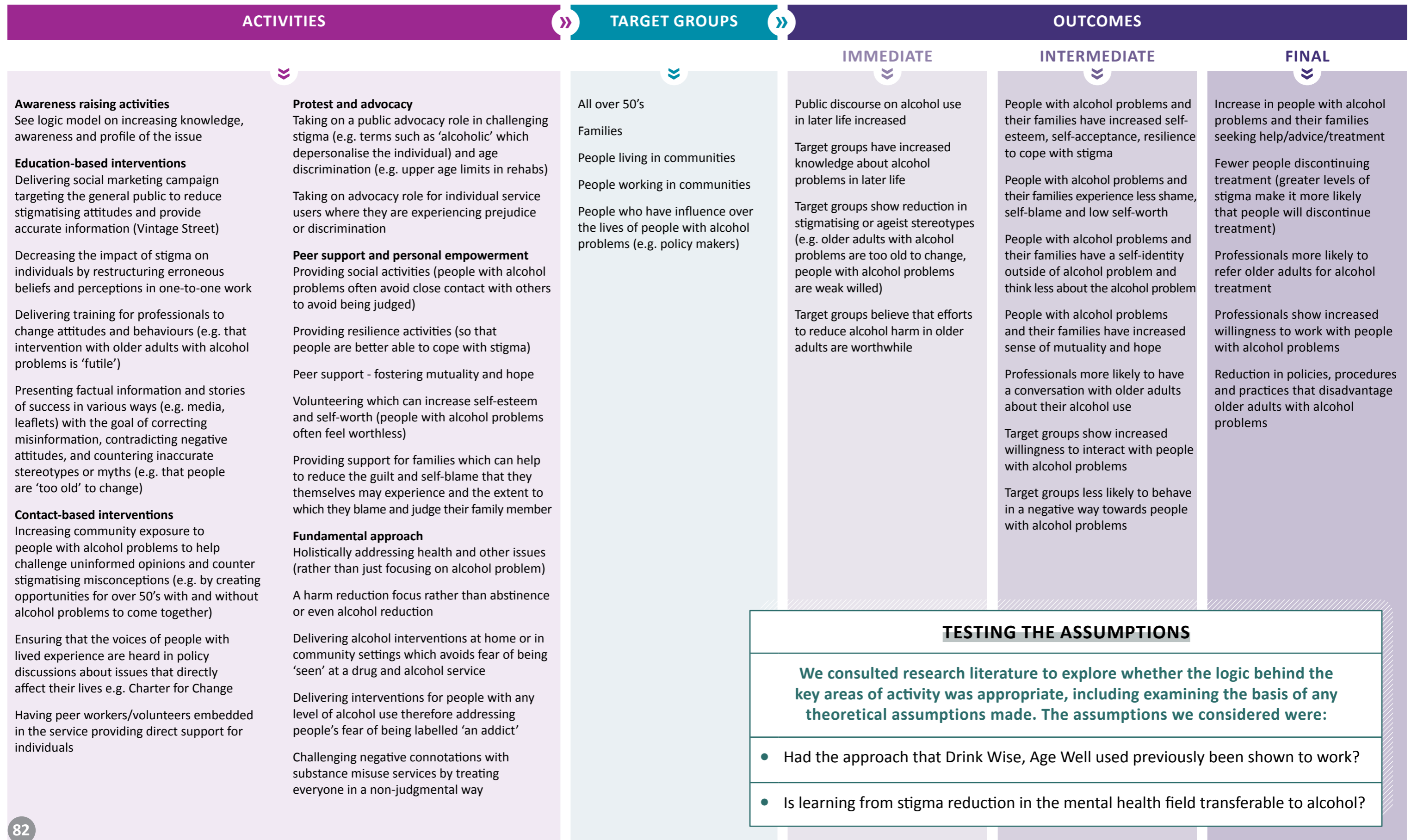
Older adults with alcohol problems face stereotyping, prejudice and discrimination not only because of their alcohol problem but also their age. Drink Wise, Age Well was not a stigma-reduction programme but reducing stigma was a common thread running through the activities. The strategy for reducing stigma was based on evidence-based approaches to stigma reduction in the mental health field because there is very little research on what works in reducing stigma in relation to alcohol problems.

The stigma-reduction activities targeted the general population, communities, organisations, families and individuals experiencing alcohol problems. Activities which worked well were education and training to normalise discussion about alcohol use, improve knowledge and reduce stigmatising attitudes and ageist stereotypes, a social-media campaign to reduce stigmatising attitudes, provide accurate information and increase support and sympathy for older adults with alcohol problems and policy influencing to reduce structural stigma. The most successful stigma-reduction activities that Drink Wise, Age Well delivered targeted people with alcohol problems. They challenged peoples' negative beliefs and perceptions about themselves through one-to-one support, helped them to cope with experiences of stigma and discrimination through resilience activities, provided them with a new sense of purpose and self-identity outside of their alcohol problem through social activities and volunteering and fostered mutual understanding and hope through peer support.

However, there was no evidence that the programme reduced stigma among family members. Most of the stigma-reduction activities were short-term and may only have had a short-term impact. The evidence mostly related to changes in attitudes, not behaviour such as professionals being more likely to refer older adults for alcohol treatment. Opportunities were missed to bring together older adults with alcohol problems and people who may stigmatise them with the goal of fostering more positive attitudes. This strategy has been shown to be very effective in reducing mental health stigma.



LOGIC MODEL: REDUCING STIGMA



What works in reducing mental health stigma?

The approach that Drink Wise, Age Well used was largely based on what has been shown to work in the mental health field. This is because there is very little research on what works in reducing stigma in relation to alcohol problems but research from the mental health field is more extensive. In the mental health field, education and contact are two general strategies. Education involves providing accurate, factual, objective and unbiased information in order to replace common myths with facts. Although education approaches are most commonly used to tackle public stigma, they have also been used to reduce self-stigma.^[125, 126]

Contact-based approaches involve people with lived experience of alcohol problems interacting with the public or with members of a stigmatised group themselves (as peers). This involves describing their challenges, strategies for recovery, and stories of success. These strategies are aimed at reducing public stigma on a person-to-person basis and have also been shown to reduce self-stigma in people who take part by creating a sense of empowerment and boosting self-esteem.^[127]

Education approaches bring about short term changes in attitude towards people with mental health issues but are less effective in the long term.^[128, 129] Contact approaches are more effective than education approaches at bringing about attitudinal and behaviour change.^[130] A combination of contact and education approaches is most effective in tackling stigma.^[128, 131]

Is learning from stigma reduction in the mental health field transferable to alcohol?

We considered whether learning from the mental health field could reasonably be applied to alcohol problems. After all, alcohol problems have a unique stigma. Alcohol stigma often goes hand in hand with the belief that alcohol use is a personal decision, and that that people with alcohol problems do not deserve sympathy.^[132] Compared with people living with other mental health problems, people experiencing alcohol problems are highly stigmatised: they are more likely to be held responsible for their own condition, more likely to be socially excluded and are at special risk for structural discrimination.^[133]

On the other hand, the causes of stigma (like fear, lack of awareness and our use of stereotypes) and the way that stigma is exhibited or experienced (such as direct discrimination, thoughts or feelings about a person living with the problem, self-stigma) are similar for all types of stigma. Learning from the mental health field has been applied to strategy to reduce other types of stigma including HIV stigma.^[134] Like people with alcohol problems, people living with HIV are also subjected to judgement and blame. Therefore it was logical for Drink Wise, Age Well to base its stigma reduction activities on what has been shown to work in the mental health field in the absence of good evidence on how to reduce alcohol-related stigma.



EVIDENCE IN RELATION TO THE LOGIC MODEL

IMMEDIATE OUTCOMES	
OUTCOME	EVIDENCE SUMMARY
Public discourse on alcohol use in later life increased	<p>Drink Wise, Age Well staff had conversations with 58,944 members of the public at public stalls. 18,858 older adults attended a workshop on alcohol use in later life. One person said:</p> <p>“ I was recently talking to a friend and she told me that while on the bus she overheard a woman telling her friend that she had been drinking far less recently. She went on to explain that this was due to the support she had been receiving from a new programme called Drink Wise, Age Well. The woman went on to say that the support was great and she was also carrying one of our promotional bags.</p> <p>A manager from a trade union said:</p> <p>“ I believe it [Drink Wise, Age Well training] has helped our members be more open about their alcohol use and therefore this has reduced the stigma of being a ‘drinker’.</p>
Target groups have increased knowledge about alcohol problems in later life	<p>18,858 older adults attended workshops on alcohol use in later life. Following the session, 94% of participants said that their knowledge and understanding of alcohol had increased. Training was also delivered to 9,750 professionals from more than 150 organisations including the police, the fire and rescue service, Citizens Advice Bureau, the NHS, the 911 service, trade unions and care homes. 97% of professionals said their understanding of alcohol had increased. One person said:</p> <p>“ I’m still thinking about it [the course] whereas I’ve been on lots of courses and the next day you’ve forgotten all about it but for some reason, this one really has resonated over time.</p>
Target groups show reduction in stigmatising or ageist stereotypes	<p>Drink Wise, Age Well developed a UK-wide social media campaign targeting the general public to reduce stigmatising attitudes, provide accurate information and increase public sympathy for older adults with alcohol problems which reached more than a million people. 83% of people who saw the campaign are now more likely to believe that society should treat older adults with alcohol problems with a tolerant attitude. Interview talk suggested people who received the Drink Wise, Age Well training were rejecting ageist assumptions for example one person said “it’s never too late to start a new journey” (there is a myth that older adults are too old to change). An employer said:</p> <p>“ Everybody assumes that because you’ve got an 18 year old that finishes work on a Friday night and stays comatose until Monday morning, that they are the ones at the most risk. You don’t actually see that if we look at the other end of the scale and let’s have a look at somebody in their 60s and how that is impacting. It blew away this weekend myth of teenagers, to actually think, ‘Ooh blimey, let’s have a look’ [there is a myth that only young people experience alcohol problems].</p>

IMMEDIATE OUTCOMES	
OUTCOME	EVIDENCE SUMMARY
Target groups believe that efforts to reduce alcohol harm in older adults are worthwhile	<p>Research from the Drink Wise, Age Well Calling Time report has been cited by:</p> <ul style="list-style-type: none"> • The Scottish Government to make a case that older adults should be a priority group in terms of reducing alcohol harm • The Drugs, Alcohol and Justice Cross-Party Parliamentary Group and All-Party Parliamentary Group on Alcohol Harm to remind alcohol services of their duty to address the needs of older adults • Alcohol Change UK to call for an end to age discrimination in alcohol services • The Royal College of Psychiatrists to draw attention to the scarcity of alcohol services for older adults <p>Commissioners and other stakeholders generally felt that the work of Drink Wise, Age Well was worthwhile. A programme participants said:</p> <p>“ Possibly it’s because we feel, of a certain age group that we have been neglected and now that you’re not neglecting us, you’re saying if you want to live a healthy and rewarding life, you’ve got to do something about an addiction that you know is not doing your health any good.</p>
INTERMEDIATE OUTCOMES	
OUTCOME	EVIDENCE SUMMARY
People with alcohol problems and their families have increased self-esteem, self-acceptance, resilience to cope with stigma (continued over...)	<p>5,800 people attended the alcohol intervention service for people with alcohol problems. There was a statistically significant increase in wellbeing between entry and exit. 5,158 social activities were held and 45,611 attended them. Not everyone who took part in the social activities had an alcohol problem but of those who attended the activities, 93% said it had helped them feel better in themselves. Similarly, not everyone who participated in the taught course to increase resilience had an alcohol problem but amongst people who attended the course, there was a statistically significant increase in resilience (measured by the Brief Resilience Scale). People who participated in the alcohol intervention service talked a lot in interviews about increased self-esteem and self-respect. For example, programme participants said:</p> <p>“ I have my relationship and my home back. I am returning to work shortly and have regained my self-respect.</p> <p>“ I have regained control with their help and I’m very proud of my achievement.</p>

INTERMEDIATE OUTCOMES

OUTCOME	EVIDENCE SUMMARY
	<p>197 family members received the service. On average there was a 50% reduction in “family burden” which is a measure of a combination of the negative impact of the problem, the family member's physical and psychological well-being and styles of coping commonly associated with increased stress and strain. One family member said:</p> <p>“ I don't think it [his wife starting to drink again] will have the same impact as what it used to have because I feel more confident, more stronger, more able to deal with things better now...[and]...instead of walking on glass... I'm able to talk to her now.</p>
<p>People with alcohol problems and their families experience less shame, self-blame and low self-worth</p>	<p>There is a significant amount of evidence from interviews with people with alcohol problems who received the service that they experience less shame, self-blame and low self-worth. For example, people told us:</p> <p>“ I didn't need to feel ashamed anymore... I was so ashamed of myself, that I'd got myself to this point, that I'd let myself get like this. But after I'd been going a while I thought 'actually, I don't need to feel ashamed, it's just life'...</p> <p>“ It's about being able to be open with people, to think it through, to talk it through, to get some space. Not to spend your entire time feeling useless and a complete mess. You get a bit of respect in yourself.</p> <p>“ They've just helped me so much to realise I'm not such a total failure.</p> <p>“ It's helped me to deal or get rid of my negative thinking. The thinking that I will put myself down. If I did something wrong in the past, I've berated myself about it. This time when I did pick up a drink, I didn't berate myself over it and I thought 'no this is stupid, just fess up at the group, put it down to experience, get up and move on'.</p> <p>We weren't able to identify any evidence that family members experienced less shame, self-blame and low self-worth.</p>

INTERMEDIATE OUTCOMES

OUTCOME	EVIDENCE SUMMARY
<p>People with alcohol problems and their families have a self-identity outside of alcohol problem, less frequent thinking about alcohol problem</p>	<p>There was an 83% increase in sense of purpose in people attending peer support groups. There was a significant amount of evidence from interviews with those who had received support from the alcohol intervention service, some of whom also attended the social activities. For example, people told us:</p> <p>“ I feel more sort of normal rather than the stigma of I drink too much and that's all there is to me, I feel I can still do other things.</p> <p>“ I think it's working for me because it's people working alongside me, it's not disconnected to the rest of my life, so it's working with me as a whole person, not just as somebody that drinks too much.</p> <p>“ I had done something positive, rewarding and enjoyable instead of just sitting in my flat on my own watching the television and having a cigarette and a glass of wine. I felt I'd been out and I was with people and we all got on so well and we'd hug each other goodbye or go off shopping together afterwards. It wasn't just “time's up, goodbye” and going home it was “what shall we do now?” and one would say “do you fancy having a look around the shops?” and before I knew it, I was doing things that I wouldn't have dreamt of, just actually going into a shop.</p> <p>“ And for me, not just me but I think several of us are very excited about the notion of this show (art show organised by Drink Wise, Age Well) because it's a focus, outside of the alcohol situation, becomes a purpose, there becomes a goal and I think that's what the alcohol intervention service worker has recognised. There's quite a few of us that we do have other means by which to express ourselves outside of drinking and so let's utilise that.</p>

INTERMEDIATE OUTCOMES

OUTCOME	EVIDENCE SUMMARY
<p>People with alcohol problems and their families have increased sense of mutuality and hope</p>	<p>2,604 peer support groups were facilitated, and 1,096 people attended. There is a significant amount of evidence from interviews with people with alcohol problems that they have an increased sense of mutuality and hope. For example, people told us:</p> <p>“ I met other people who were struggling with controlling their drinking. I found it very comforting that I wasn't alone.</p> <p>“ It was good to learn that there are other people like me out there and there is help and support available</p> <p>“ Hope and shared experience.... It's almost like holding a torch, that's how I perceive it.</p> <p>“ We support each other and part of that is taking on the responsibility for someone other than your bloody self...Coming together....making the effort to behave or arrive without a drink.</p> <p>“ The main thing is hope; it's partly about being in a room with people who feel the same. It's not just the counsellors, it's everybody else. Everybody has lived through life a certain way, they've picked up tools along the way. So we can all help each other in certain ways.</p> <p>There was less evidence that families have increased sense of mutuality and hope. One family member who had attended a group for families told us:</p> <p>“ Knowing that there's somebody there that I can talk to... I've got great family...who I can go to any time, no problem...but it's not, you can't go and explain things the way they actually are because you don't ... they're not things you want to go talking to your family about... You can be more honest when you come to these [Drink Wise, Age Well] groups...and tell it how it is and not paint nice pictures.</p>

INTERMEDIATE OUTCOMES

OUTCOME	EVIDENCE SUMMARY
<p>Professionals more likely to have a conversation with older adults about their alcohol use</p>	<p>Professionals who received training were asked to rate their confidence in talking to older adults about alcohol before and after the course. 73% reported an increase in confidence and 90% said they would make changes to their practice. One of the most common changes they said they would make in their feedback was to have more conversation with older adults about alcohol use. For example:</p> <p>“ Approach talking about alcohol more confidently rather than bypassing where there is an obvious issue.</p> <p>“ Talk more about drinking alcohol and keep it brief to plant the seed, particularly if someone is being affected by alcohol.</p> <p>“ Being more confident in striking up a conversation about a person's drinking problems and support their access to support.</p> <p>“ Asking service users about their alcohol intake is now part of my core assessment during a first home visit. I have felt that by implementing this across the board that the topic has become a more natural and less cautious topic for me to raise – I no longer feel anxious in asking about an individual's alcohol consumption.</p>
<p>Target groups show increased willingness to interact with people with alcohol problems</p>	<p>No data.</p>
<p>Target groups less likely to behave in a negative way towards people with alcohol problems</p>	<p>No data.</p>

FINAL OUTCOMES

OUTCOME	EVIDENCE SUMMARY
<p>Increase in people with alcohol problems and their families seeking help/advice/treatment</p>	<p>7,529 older adults sought face-to-face help from Drink Wise, Age Well and a further 641 older adults accessed help through the anonymous on-line webchat service. 337 family members sought help. 30,469 people engaged in conversations on public stalls said they were seeking advice for themselves.</p>
<p>Fewer people discontinuing treatment (greater levels of stigma make it more likely that people will discontinue treatment)</p>	<p>Analysis of outcome data showed that, compared to people aged 50 and over attending mixed-age services, Drink Wise, Age Well service users were less likely to discontinue (disengage from) treatment. People talked about feeling less 'judged' in the Drink Wise, Age Well service than they had in previous alcohol services they had attended.</p>
<p>Professionals more likely to refer older adults for alcohol treatment</p>	<p>No data.</p>
<p>Professionals show increased willingness to work with people with alcohol problems</p>	<p>No data.</p>
<p>Reduction in policies, procedures and practices that disadvantage older adults with alcohol problems</p>	<p>Drink Wise, Age Well lobbied Public Health England to take action to stop rehabs setting upper age limits on their online directory of rehabs making it easier for older adults to access rehabs.</p>



DRINK WISE, AGE WELL AND ENGAGING MINORITY ETHNIC POPULATIONS

Drink Wise, Age Well strived to be inclusive of minority ethnic groups. This proved to be challenging for a number of reasons. Firstly, a whole population approach was found less effective for reaching minority ethnic groups as different cultural factors shape attitudes to alcohol use and help-seeking across ethnic communities.^[135]

The literature points to specific barriers in reaching ethnic minorities with alcohol interventions, including: cultural barriers (especially in cultures where there is a religious restriction on alcohol use and/or it is a taboo subject), challenges around using gatekeepers (especially where there might be fears of breach of confidentiality within the community) or language barriers.^[135] Therefore, reaching minority ethnic communities requires a more targeted approach, which was also the experience of Drink Wise, Age Well. One method undertaken by Drink Wise, Age Well to target minority ethnic groups was linking up with existing minority ethnic community groups and building relationships of trust over a longer period of time. While such actions were generally successful, considering the small numbers engaged this way they appeared an ineffective use of project resources. In general, finding the best ways for reaching minority ethnic communities took time and additional effort. It was found that using images and language reflective of local ethnic minorities in project advertising was very important. Finding the right outlets for outreach was also key.

For example, running clinics at GP surgeries (which were advertised through text messaging by the surgery) appeared to work very well for reaching over 50s across the board, including ethnic minority populations. It was concluded that locating Drink Wise, Age Well clinics in GP surgeries with high numbers of ethnic minority patients would be an effective way of engaging ethnically diverse communities.

Drink Wise, Age Well's experiences of reaching minority ethnic groups point to the importance of local contexts for finding the most efficient ways of doing so. For instance, the Sheffield Drink Wise, Age Well team established an allotment in a highly deprived area of the city with a high ratio of ethnic minority residents. This proved successful for engaging people from a variety of minority ethnic groups in alcohol intervention services and other project activities. Tailoring activities to preferences of particular groups also increased engagement, such as delivering customised workshops for given minority ethnic community groups. Overall, it was the non-alcohol focused resilience activities, such as social events, which attracted the highest numbers of ethnic minority participants (which also stands true for the White British population), and especially outdoor and sports- or health-related activities.

Summing up, Drink Wise, Age Well was successful in engaging minority ethnic communities to a certain extent. The whole population approach proved inadequate in the case of ethnically diverse populations; hence a more targeted approach was adopted. Building relationships, finding most efficient ways of approaching given minority ethnic communities and building trust within these communities took time and additional effort. Despite these efforts, the overall numbers of Drink Wise, Age Well programme participants of ethnic minority background remained low: only 1.6% of the alcohol intervention service users across the UK were from an ethnic minority. The non-alcohol focused resilience activities attracted higher numbers of ethnic minority participants with an average of 4.6% across the UK. Of all the demonstration areas, Drink Wise, Age Well in Sheffield engaged the largest numbers of ethnic minority programme participants in all project activities, with e.g. 6.6% of people using the intensive alcohol service and 15% engaging in social events being from an ethnic minority group.

This is reflective of the highest ratio of ethnic minority residents in Sheffield among all the demonstration areas at 16.3%. Similarly, Glasgow came second in terms of ethnic minority engagement which is also reflective of its overall population structure with 12% of the city's residents being of an ethnic minority background. Conversely, in Wales, Devon and Northern Ireland especially, where the ratio of ethnic minority populations is considerably lower (at 6.3%, 5.1% and 1.8%, respectively), so were their levels of engagement with Drink Wise, Age Well. The relatively modest engagement of ethnic minorities in Drink Wise, Age Well may also be attributed to cultural barriers (including community shame, stigma and exclusion), and the generally lower levels of problem alcohol use within ethnic minority communities as compared to the majority White population in the UK.^[136-140] While some minorities, such as the Irish, Polish or Sikh, appear to have higher levels of problem drinking, this often remains unrevealed to alcohol services due to a reluctance to seek help.^[135, 136, 141-143] Therefore, the minorities most in need of alcohol support might be less likely to engage in alcohol intervention programmes such as Drink Wise, Age Well.

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