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**University of
Sunderland**

**A Mixed Methods Investigation of Alcohol use in Sheltered
Accommodation**

Annette Payne

**A thesis submitted in partial fulfilment of the requirements of the
University of Sunderland for the degree of Doctor of Philosophy**

PhD

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Abstract

Alcohol use in later life has received little attention. Among older people psychosocial factors including bereavement, retirement, boredom, loneliness, and depression are associated with higher rates of alcohol use. The loss of a home has been compared to bereavement; therefore, where older people live has an impact on the quality of their lives (Tinker, 1997). This thesis focuses on alcohol use of older people who live in sheltered accommodation in Newcastle upon Tyne. No published work has been conducted on this population to date and therefore it is not known whether or why they drink at different levels to the general population of older people because of their loss of their home.

The population for this research was people living in sheltered accommodation in one city in the North East of England. Sheltered accommodation is housing designed to help older people live independently, where there is support available onsite. Alcohol use in residents of sheltered accommodation was assessed in two studies.

The aim of Study 1 was to investigate the levels at which the sheltered housing population are consuming alcohol. The study comprised of a postal survey using the alcohol disorders identification test survey tool (AUDIT) (Babour, Higgins-Biddle, Sanders et al, 2001). The AUDIT score is a method of measuring a person's risk from alcohol related harm which goes beyond purely measuring consumption as it also measures the frequency of use and the effect of alcohol use. Data were analysed using SPSS. Findings showed that

men in the research population scored higher than the women and that the younger age group (<70) had higher scores than the other two age groups (71-80 and >80).

The aim of Study 2 was to investigate the factors determining decisions to drink in later life. Study 2 comprised 16 in-depth interviews using a life course approach. Data were analysed using a framework approach with a biographic narrative overlay. Findings showed that there were a number of factors influencing the decision to drink to harmful and or hazardous levels including mental health, domestic violence, social contact, family and work. Case studies were developed and presented based on these findings.

This research found that older people's lives do not simplify as they age and therefore the reasons for using alcohol are complicated and individualised. They are influenced by early life experiences, traumatic or life changing events as well as the strength of the person's locus of control. Further work is needed to establish support needs for drinkers in later life, both to reduce drinking levels and to reduce harms from current levels of drinking. Older people are the group who are most likely to lack knowledge of what these units and limits are (McInnes & Powell, 1994). An older person specific unit guide should be developed and implemented. There needs to be improved multidisciplinary staff training to facilitate an increase in the identification of those older people who consume over the advised alcohol limits. Policy should consider the move away from a one size fits all model of alcohol management to a more individualised approach to support the adjustment of later life events

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Declaration

I declare that the work contained in this thesis has not been submitted for any other award and that it is all my own work. I also confirm that this work fully acknowledges opinions, ideas and contributions from the work of others.

Any ethical clearance has been approved by Sunderland University

I declare that the word count for this thesis is words 57,725

Name Annette Payne

Awards

Newcastle upon Tyne NHS Hospitals Foundation Trust Annual Nursing Award

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Poster presentation Fuse annual conference July

Glossary of terms, abbreviations and definitions

Terms

Older person 55 years and over

Adult 18 or over

Child/younger person under 18

The researcher Annette Payne

Abbreviations

AUDIT Alcohol Use Disorders Identification Test

CAGE Cut down, Annoyed, Guilty, Eye opener

CMO Chief Medical Officer

DoH Department of Health

EAC Elderly Accommodation Council

ID Identification

NHS National Health Service

ONS Office for National Statistics

NMC Nursing and Midwifery Council

NHS National Health Service

PH Public Health

PhD Philosophy Doctorate

RCP Royal College of Psychiatrists

SPSS Statistical Package for the Social Sciences

Definitions

Risky drinker- those exceeding daily, weekly; or per occasion alcohol consumption thresholds. Audit score 0-7

Harmful drinker- those that exhibit physical, social or psychological harm, without meeting the criteria for dependence. Audit score 8-19

Alcohol dependant- those that continue to use alcohol despite significant negative physical psychological and social consequence. Audit score 20+

Binge drinking- more than eight units of alcohol in a single session for men and more than six units for women

Sheltered accommodation- accommodation designed to help older people live independently with support via a warden available.

The home- the social, cultural and economic structure created by the household

The dwelling- is the physical structure providing shelter and the necessary space, facilities and amenities for the household.

Chapter 1 Introduction

Initial ideas

The initial idea for this doctoral study arose from the researcher's general interest in the impact that housing has, not only upon a person's health but their general ability to cope with life events. This interest has developed over 23 years of nursing practice in various roles from surgical staff nurse to a district nursing sister. As a qualified nurse the researcher made a conscious move into the area of community nursing. The impact of the home environment was tangible with most patients even while being cared for in the hospital setting. A move to the community increased the researchers interest in the wider determinants of health, such as housing and the older client groups. As a district nursing sister, the researcher felt an affinity with the older people who were being provided with care, the life stories, the passing of knowledge from the past to the present was a constant source of intrigue.

The work experiences the researcher had gained forged itself into a doctoral research idea of some substance during an informal conversation with Professor Crosland who asked a question about alcohol use within this population which sparked an interest in the topic.

While the ideas for the research were developing the local authority in Newcastle upon Tyne was tasked with producing an information leaflet specifically for older people. The researcher was invited to become involved in the consultation with older volunteers. This work cemented the idea that the levels of alcohol consumption of older people in sheltered housing were

unknown. A natural progression was to complete a PhD that brought these components together.

Background

In 2016 the population of the UK was 65.6 million and it is projected to continue growing, reaching over 74 million by 2039 (ONS, 2017). It is predicted that by 2031 there will be 27.2 million people aged 50 years and over, with one in four people aged 65 and over by 2040 (Simmill-Binning et al, 2009). The changing profile of older people from a fading contributor in society to an active participant with a valid contribution; is not just about the ageing population but about understanding people's life journeys as they get older, the problems they face and the implications for housing and the wider society (Tinker, 1997; Ward, Barnes & Gahagan, 2008).

A report by Newcastle City Council (2013) stated that the ageing population is one of the key demographic challenges that will impact on the type of housing required in the city, with assistance given to people to remain independent for longer preventing or delaying the need for more costly interventions from both health and social care. Those aged 65 and over make up to 14% of the Newcastle population with projections showing that this population is likely to increase by 15% by 2020. Newcastle had 21,560 over 65's with a limiting long-term illness which is predicted to rise to 24,385 by 2020, 16,800 over 65's who are unable to manage at least one domestic task set to rise to 19,010 by 2020 and 13,800 people aged 65 and over who were unable to manage at least one self-care task is set to rise to 15,600 by 2020 (Newcastle City Council, 2013). It has been estimated that in 2015 approximately 60,000 people in the UK

experienced multiple needs including mental ill health, substance misuse, offending behaviour, family breakdown and homelessness (Drinkwater et al, 2011). This increase in population and the amount of health and social care need anticipated to be required in the Newcastle population means that there will be an increased demand for supported accommodation and services for older people.

There is a risk that if unsupported, older people misusing alcohol could lose their home through lack of independence, failure to maintain their property or keep up with rent or mortgage payments or due to becoming a nuisance neighbour (Giles, 2016). The sheltered housing environment is distinct as tenants usually move to this type of accommodation when they require some degree of support but are to all intents and purposes living as independently as they are able (EAC, 2012). Among older people psychosocial factors including bereavement, retirement, boredom, loneliness, homelessness and depression are associated with higher rates of alcohol use (Crane & Warnes, 2001). The loss of a home has been argued as akin to bereavement, therefore where older people live and their surroundings have an impact on the quality of their lives (Tinker, 1997). Considering the future population increase in older people it is important to consider that there will be an increased demand on all types of accommodation including sheltered housing (Newcastle City Council, 2012).

The current safe limits for alcohol consumption are based on work with younger adults and were updated from the guidelines issued in 1995 to new guidance released by the Chief Medical Officer (CMO) in 2016 (DoH, 2016).

Due to the physiological and metabolic changes associated with ageing these safe limits are likely to be too high for older people with a proposition that the safe upper limit should be reduced to one and a half units per day (Dunne & Schipperheijn, 1989). The National Health Service has so far failed to develop models to address the needs of older people with substance use problems. The planning and provision of services is characterised by a disturbing silence. One of the most significant advances in highlighting the need for assessment and treatment of excessive alcohol use in the older population has been the publication of the second report of the UK inquiry into mental health and wellbeing in later life (Age Concern, 2007). This report draws attention to several areas including the high alcohol related death rates in the 55-74-year-old age group, the need to pay closer attention to invisible groups, detection, treatment and referral irrespective of age (Age Concern, 2007). The prevalence of increased risk drinking in England in 2016 was 26% of men and 12% of women. This included 5% of men and 3% of women whose drinking could be categorized as 'higher risk' (defined as over 35 units for women and over 50 units for men). For men and women, the highest prevalence of people drinking above the low risk guidance was in 55 to 64-year old's. Almost a third (30%) of this age group drink more than 14 units a week (ONS, 2017a). Heavy drinking among older people is likely to be more widespread than dependant drinking coupled with a rise in life expectancy within this population group, attention to older people and alcohol misuse is warranted (Mirand & Welte, 1996; Johnson, 2000; O'Connell et al, 2003; Wilson et al, 2013). Alcohol and drugs are amongst the top ten risk factors for mortality and morbidity in Europe,

and substance misuse by older people is now a growing public health concern (Public Health England, 2016).

Structure of thesis

This thesis is structured along the completion of two consecutive research studies. The aim of Study 1 was to investigate the levels at which the sheltered housing population are consuming alcohol. The aim of Study 2 was to investigate the factors determining decisions to drink in later life.

Chapter 2 presents a critical discussion of the literature underpinning the area of older people, alcohol and housing. This review provides an overview of the sources explored and places each study in the context of its contribution to understanding the research problem being studied, the factors determining why older people drink. The literature review also aimed to identify gaps in the literature while placing this research within the context of existing literature. The literature frames the research aims including defining the ageing population, housing with care, alcohol use and recommended limits, alcohol screening, alcohol use in older people, public health policy and health improvement models.

Chapter 3 presents the research structure underpinning the philosophical stance, ontological considerations, epistemological considerations, the theoretical perspectives and ethical considerations for both Study 1 and Study 2.

Chapter 4 presents the methodology and results for Study 1. The aim of Study 1 was to investigate the levels at which the sheltered housing population were drinking. There were anecdotal reports of high levels of alcohol use among the sheltered housing population and it was the first aim of this research to establish the actual level of alcohol consumption rather than accept anecdotal reporting. This chapter discusses the methods employed in carrying out Study 1 including the practical data collection and analysis methods. This chapter includes the detail on the sampling, research packs, the coding of the data and the analysis via SPSS. The results were presented followed by a chapter summary of this study.

Chapter 5 presents the methodology and results for Study 2. The knowledge gained from the results of Study 1 frame and informs Study 2. Although the two studies are distinct pieces of work, Study 1 to consider prevalence and Study 2 to investigate factors determining the decision to drink, the mixed methods contribute to each other. Study 2 ran consecutively to Study 1. The qualitative methods in this study aimed to collect data relating to the factors determining the decisions to drink in later life. Semi structured, life course interviews with a life grid were utilised for data collection. The interviews were recorded and transcribed verbatim. The semi structured format followed a life course approach taking the interviewee from birth to current day, the use of a life grid was utilised where the interviewee struggled to place their personal timeline. The interviews were analysed using a framework approach with a biographical narrative and examples of the thematic development are included in this chapter. The results were presented as the thematic elements.

Chapter 6 presents case studies from the interviews. These detail the understanding that the participants attribute to their life stories. The narrative places the data collected into the context of the person's life.

Chapter 7 presents a discussion of the Study 2 results under the themes of domestic violence, work, family, social contact and mental health. The chapter links the findings to the literature with discussion of older people's alcohol use, isolation and loneliness, life transitions, retirement and locus of control.

Chapter 8 presents a reflection by the researcher. This chapter discusses what reflection is, and its potential impact on practice from a professional and academic perspective.

Chapter 9 provides an overview of the research, highlighting the main findings, the contribution to knowledge and the implications of the findings from Study 1 and Study 2 for both policy and further research.

Chapter 2 Review of the Literature

The purpose of this chapter is to critically discuss the literature underpinning the area of older people, alcohol and housing. This review provides an overview of the sources explored and places each study in the context of its contribution to understanding the research problem being studied, the factors determining why older people drink. The literature review also aimed to identify gaps in the literature while placing this research within the context of existing literature. The initial section of this chapter outlines the methodology used during the literature review followed by the specifics of the search parameters. The following sections discuss alcohol use in the general population; the setting of the scene in relation to the UK's ageing population and the repercussions of its changing demographic, the guidelines for alcohol use, screening and detection of harmful and hazardous alcohol use, a recent housing history, older person's inclusion in research and the life course.

2.1 Literature review methodology

A narrative method was employed to carry out the literature search, this is essential for gaining in depth insight into specific subject areas, refining the research question and identifying any gaps in the existing research (Baumeister & Leary, 1997). The aim of the literature search was to review, critique, summarise and synthesise the literature in relation to older persons alcohol use within sheltered accommodation. This facilitated the scoping of existing research in the field and identified areas yet to be investigated. While the methodology adopted to review the literature is not the same as a

systematic review; which uses a rigorous criterion to sift the literature on a topic, the principles and structure of the systematic review helped inform the approach used (Timmons & McCabe, 2005). There was no literature published on the specific research topic, older people living in sheltered accommodation. A narrative approach to the literature review enabled a degree of flexibility to the inclusion of literature to give a broad perspective on alcohol use, older people and housing that a standard systematic review would not provide. For there to be a systematic review there needs to be literature that can be reviewed against a criterion and this becomes problematic if there is little written specifically on the subject to be considered or if what is written is very diverse.

The flexibility offered by a narrative methodology gave the ability to change and adapt as the literature review progressed to include ideas, theories and concepts from a wide range of literature which might have otherwise been excluded (Kiteley & Stogdon, 2014). This could cause researcher bias surrounding decisions of what to include and exclude and make a replication of the review problematic (Petticrew & Roberts, 2006).

There were four main stages in developing this literature review including the development of a search strategy, identifying inclusion and exclusion criteria, analysing the literature, refreshing the review.

2.2 Search strategy

The decision was made to follow a narrative methodology as there would need to be a controlled broad literature search in order to capture the plethora of work on alcohol but allow for specificity to search for alcohol, older people and supported accommodation. The initial search used a broad and inclusive approach focussing on all of the aspects of the research topic. Search terms used were older people and housing, older people and alcohol use, older people in sheltered accommodation and alcohol use, alcohol use in retirement communities, screening tools for alcohol use, older people and alcohol misuse. The literature reviewed was not limited to the UK but included research from around the world. This facilitated a broad insight into alcohol use and older people.

2.3 Search parameters

The literature review was initially carried out between October 2010 and May 2011 and revisited and updated on three occasions 2013, 2016 and 2017. There were no date parameters set for the literature search as the topic had not been researched until this point and so it was important to be sure there was no other work that could be drawn upon. There was a decision to include Government papers from the search so that the current best practice could be taken into account. The literature was searched using The University of Sunderland's library catalogue with access to journals and electronic databases including Medline, CINAHL, Zetoc, scoINdex, EMBASE, pubmed and Web of Science. Email alerts were set up with relevant databases and journals to keep up to date with any newly published literature.

On occasion literature that appeared to be relevant based on the search results, title and abstract was found not to be directly relevant only once the literature had been read. Although arguably contributing to wider knowledge, some research was not directly transferable to the research topic, for example veteran's communities in the USA differ in terms of being ex armed services, predominantly male and are whole communities rather than sheltered housing communities in the UK. As alcohol research and older persons research is diverse there was the acknowledged risk of distraction from the topic of the research for this thesis. The literature search included papers which focused on addiction services, inpatient treatment, the younger person's binge drinking culture, younger persons services, studies from other countries such as veteran's communities in the USA, alcohol brief interventions evaluation, screening tool evaluation, housing history, the effects of alcohol on an ageing body.

2.4 Defining the ageing population

The World Health Organisation (WHO, 2002) highlight that there is no definitive definition of older people with most developed world countries accepting the chronological age of 65 years as a definition. Older people are generally defined according to a range of characteristics including their chronological age, a change in social role and a change in functional ability (World Confederation for Physical Therapy, 2017). If a combination of factors is to be considered then actually chronological age might not be the defining factor in determining old age. The WCPT accept old age to be 60-65 years of age in line with retirement; however, if retirement is taken as a marker for the

transition into old age then this will keep shifting as the retirement age is not fixed moving from 60-67 years in the UK recently.

In some countries 50 is taken as the defined age of an older person (WCPT, 2017). For this research the criterion was set by the age at which a person could apply to live in age designated sheltered housing accommodation. This was set at 55 years of age but had the proviso that a younger person could move in if they met the criteria for an older person other than chronological age for example they had health and social care needs and were of poor health.

In 2016 the population of the UK was 65.6 million and it is projected to continue growing, reaching over 74 million by 2039 (ONS, 2017). The proportion of older people in the population has continued to rise throughout the latter half of the 20th century (Lakhani, 1997) with 20 million people aged 50 years and over in the UK in 2003 (Simmill-Binning, Paylor & Wilson, 2009). This equates to a 45% increase over five decades from 13.8 million in 1951 (Simmill-Binning, et al, 2009). It is predicted that by 2031 there will be 27.2 million people aged 50 years and over, with one in four people aged 65 and over by 2040. (Simmill-Binning et al, 2009). As a result of the ageing population the old age dependency ratio (OADR) is increasing. The OADR is the number of people over 65 years old for every 1000 people age 16 and 64 years old. In mid-2016 the UK's OADR was 255. It is a useful measure to understand how the balance in the population will change, particularly when planning for the needs of the different age groups (ONS, 2017).

The changing profile of older people from a fading contributor in society to an active participant with a valid contribution is not just about the ageing population but about understanding people's life journeys as they get older, the problems they face and the implications for housing and the wider society (Tinker, 1997; Ward, Barnes & Gahagan, 2008). The societal view of ageing is a process of deterioration, dependency, reduced potential, family dispersal and digital incompetence (Rose, 2016). The gradual withdrawal of older people from the workplace and social relationships may be so but each generation of older people is becoming increasingly more educated resulting in those who are older, healthy, and educated placing even more emphasis on the quality of life (Kwok & Tsan, 2011). Those older people who hold a negative view of ageing well are less likely to engage in preventative lifestyle behaviours such as physical exercise, eating a balanced diet and minimising alcohol and tobacco use (Rose, 2016). There is often a misplaced view that all older people are vulnerable and in need of protection from research (McMurdo, 2011).

2.5 Housing and care

A report by Newcastle City Council (2013) states that the ageing population is one of the key demographic challenges that will impact on the type of housing required in the city, with assistance given to people to remain independent for longer preventing or delaying the need for more costly interventions from both health and social care. Those aged 65 and over make up 14% of the Newcastle population with projections showing that this population is likely to increase by 15% by 2020. Newcastle had 21,560 over 65's with a limiting long-term illness which is predicted to rise to 24,385 by 2020, 16,800 over 65's who are unable

to manage at least one domestic task set to rise to 19,010 by 2020 and 13,800 people aged 65 and over who were unable to manage at least one self-care task is set to rise to 15,600 by 2020 (Newcastle City Council, 2013). It has been estimated that in 2015 approximately 60,000 people in the UK experienced multiple needs including mental ill health, substance misuse, offending behaviour, family breakdown and homelessness (Drinkwater et al, 2011). This increase in population and the level of health and social care need anticipated to be required in the Newcastle upon Tyne population means that there will be an increased demand for supported accommodation and services for older people.

There is a risk that if unsupported, older people misusing alcohol could lose their home through lack of independence, failure to maintain their property or keep up with rent or mortgage payments or due to becoming a nuisance neighbour. (Giles, 2016). Supported self-management and self-care is an important aspect of ensuring people with long term conditions remain independent in the community (NHS England, 2016). In the worst-case scenarios older people with alcohol problems could be made homeless. While there is a duty on local authorities to rehouse those, who are statutorily homeless, certain criteria must be met. Alcohol dependency resulting in the loss of a home may be considered an intentional act, with alcohol dependency not being considered a vulnerability although mental health, physical and sensory impairments are (Giles, 2016). The right home environment is essential to health and wellbeing throughout life. It is a wider determinant of health (PHE, 2017). Older people spend more time in their home, between 70-90% more than younger people, and the home is often the focus of memories

(Giles, 2016). A life course approach is essential as the risks to health, home, environment and housing circumstances look different for different populations (PHE, 2017).

According to the Joseph Rowntree Foundation (2009) there are around 550,000 dwellings in the UK (480,000 in England) housing around five percent of the older population (older person within the Joseph Rowntree Foundation is taken to be 65 years and over). Smith-Bowers (2004) highlights the changing role of housing from the 1950s where relatively fit, healthy older people required limited support, through the 1960s-70s which saw a rapid expansion with the emphasis changing from general housing to specialist housing needs, this led to an increase of 1970s style sheltered housing which continued into the late 1980s. This resulted in concerns in the 1990s about the over provision of difficult to let sheltered housing stock. This was mainly due to much of the accommodation being bed sit style which had low desirability. The sheltered housing environment is distinct as tenants usually move to this type of accommodation when they require some degree of support but are to all intents and purposes living as independently as they are able (EAC, 2012). According to Housing Care (2010) sheltered accommodation means having your own flat or bungalow in a block or small estate, where all other residents are older people (usually over 55 years of age). With few exceptions all developments provide independent, self-contained homes with their own front door.

The 1990 NHS and Community Care Act represented a radical break from the continuum of care where the older person moved through a range of services

and specialist provision as needs increased. This went from housing solutions to institutionalised care (ordinary housing, sheltered housing, and residential care, nursing care). Post 1990 support and care were provided, as needed, to individuals in their own homes as an alternative to individualised care.

The Elderly Accommodation Counsel (EAC, 2012) identifies three categories of housing for older people according to the support provided, housing without support, housing with support and housing with support and care. Since 2006, the emphasis has been focussed on the development of community based care meeting health and social care needs including initiatives to change the design of health and social care services which has culminated in the development of housing with care with all other supported housing being largely ignored (DoH, 2006; EAC, 2012).

Sheltered housing, accommodation that is designed to help older people live independently, where there is support available onsite, has received very little attention from policy makers or researchers despite significant changes to sheltered housing in terms of modernisation over the last decade. There are increasing numbers of tenants who might not be classified as chronologically old but who have social and or health care needs that equal that of an older person, as well as large numbers of very old tenants, those who are 80 years of age and older. Sixty percent of sheltered housing residents report a disability related requirement with an increase in the need for support to manage mental health or substance use. The primary reasons for an older person to move into housing with support is either due to their current property being unsuitable as a result of ill health or a change of circumstance due to bereavement.

Among older people psychosocial factors including bereavement, retirement, boredom, loneliness, homelessness and depression are associated with higher rates of alcohol use (Crane & Warnes, 2001). The loss of a home is akin to bereavement, therefore where older people live and their surroundings have an impact on the quality of their lives (Tinker, 1997). It is expected that the next generation of older people will have higher expectations than the current generation due to the large proportion who own their own homes and therefore more attention needs to be paid to find out what type of housing should be provided for this growing population (Tinker, 1997). Ward, Barnes and Gahagan, (2005) believe that sheltered housing staff were a crucial contact point for older people and that this could be pivotal to facilitate older people's involvement in activities that could act in a preventative way to reduce alcohol consumption. Research from the USA, Australia and New Zealand highlighted knowledge of alcohol use in older people's communities and villages but no work from the UK relevant to the topic has been conducted (Alexander and Duff, 1988; Adams, 1996; Mirand & Welte, 1996; Peele & Grant, 1999). Considering the future population increase in older people it is important to consider that there will be an increased demand on all types of accommodation including sheltered housing (Newcastle City Council, 2012). Given that there is a financial threshold on those who wish to occupy social housing (financial assets must be under £80,000 to qualify in Newcastle) there is a general tendency that a local authority accommodation is occupied by those at the lower end of the social scale. People who are living in poverty may be less able to avoid or buffer the social consequences of their choices unlike their more affluent counterparts (Jones and Sumnall, 2016).

2.6 Alcohol use and recommended limits

Most adults in the UK consume alcohol and its use both influences and is influenced by social and cultural norms (Health and Social Care Information Centre, 2015). Perceptions and beliefs about the risks associated with alcohol consumption are shaped through public and policy debates. Holloway et al (2008) have argued that in England these have been overly biased towards problem drinking in public space. This may lead people to regard their own drinking practices as unremarkable (Valentine et al, 2007).

The North East has 12 of the top 20 binge drinking communities in England and the highest alcohol related hospital admissions in England (Lock et al, 2012). Binge drinking is defined as more than eight units of alcohol in a single session for men and more than six units for women, and this type of drinking is usually done with the intent to get drunk in a short space of time (ONS, 2017). There are regional variations in binge drinking along a north versus south divide that mirrors wider economic differences between the geographies (Landsbergis et al, 2014).

People who live in deprived neighbourhoods may be more likely to both abstain from alcohol than those in more affluent neighbourhoods and more commonly adopt heavier patterns of consumption such as binge drinking (Mattheson et al, 2011; Kuipers et al, 2013). It could be argued that similar types of people will adopt similar patterns of alcohol consumption, the social nature of drinking means that people tend to influence each other's drinking behaviour (Babor et al, 2010). There are no figures to determine what proportion of the estimated 13 million adults who live in poverty who overlap with the category of problem

drinkers, the extent of the problem is unknown (Jones and Sumnell, 2016). Rather policy attention in England has focussed on the number of people accessing the main welfare benefits who are also problem alcohol or drug users. In 2008 there were an estimated 159,900 dependant drinkers in receipt of one or more main benefits (Hay & Bauld, 2010). Rosen (2011) concluded that overall the evidence suggested that awarding poorer people disability benefits does not cause them to use substantially more drugs or alcohol but that they are likely to adjust their substances use around the time they receive funds if they are financially limited by poverty. The social causation hypothesis states that acute and chronic stress generated by poverty and deprivation increases the likelihood of problem alcohol use. People in lower socioeconomic positions are more likely to experience job insecurity stressors such as lack of control and poor working environment both of which are associated with alcohol dependence and problems with alcohol use (Landsbergis et al, 2014). Men with low socioeconomic position reported binge drinking more often than those with a higher social position. Low socioeconomic status at childhood and cumulative disadvantage across the life course is the strongest predictor of drinking patterns such as midlife problem drinking (Jones and Sumnell, 2016). Early years experiences may have long lasting effects on health and wellbeing (Rosenman & Rodgers, 2004). Self-reported heavy drinking was almost four times higher in those reporting four or more adverse childhood experiences compared to those reporting none (Bellis et al, 2014). A family history of poverty and alcohol dependence in childhood was associated with respondent's own alcohol use and income as adults, those who reported living with an alcoholic relative for

nine or more years and reported living in poverty for more than six years were more likely to report increased alcohol problems and lower income of their own (Kost & Smyth, 2002). Congers (1956) tension reduction hypothesis proposes that people may consume alcohol as a means of reducing, or as a response to stress. Studies have not been able to distinguish which stressors cause alcohol use but chronic stress created through the deprivations of poverty increase the likelihood of heavy drinking. The pathways that link poverty and deprivation to problem alcohol use are poorly understood.

The cost effectiveness of treating those with alcohol use disorders has been highlighted by The South West Public Health Observatory (Jvett, 2012) who state that for every £1 spent on treatment, £5 is saved by the public sector. An alcohol use disorder (which includes a level sometimes called alcohol dependant), is a pattern of alcohol use that involves problems controlling your drinking, being preoccupied with alcohol even when it causes problems, having to drink more to get the same effect or having withdrawal when you rapidly decrease or stop drinking (Pruthi, 2015).

The current safe limits for alcohol consumption are based on work with younger adults and were updated from the guidelines issued in 1995 to new guidance released by the Chief Medical Officer (CMO) in 2016 (DoH, 2016). This new guidance states that to keep the health risks from alcohol consumption to a low level no more than 14 units of alcohol should be consumed in a week and that these units should be spread over three or four days, the CMO highlight that there are no safe limits (DoH, 2016). The net benefits from small amounts of alcohol are less than previously thought and

are significant in only a limited part of the population. Women over the age of 55, for whom the maximum benefit is gained when drinking around five units a week, with some beneficial effect up to 14 units a week (DoH, 2016). Due to the physiological and metabolic changes associated with ageing these safe limits are too high for older people and that the safe upper limit should be reduced to one and a half units per day (Dunne & Schipperheijn, 1989). Drinking alcohol increases the risk of getting cancers of the mouth and throat, voice box, gullet, large bowel, liver, breast and pancreas, these risks start from any level of regular drinking and then rise with the amounts of alcohol being drunk (DoH, 2016).

The National Institute on Alcohol Abuse and Alcoholism (1995) defines moderate drinking in older adults as no more than one drink per day and excessive drinking as more than 14 drinks in a week for men and seven in a week for women or more than four drinks in a day for men and three drinks in a day for women. This is a standard set for the USA and there is no similar age-related guidance in the UK; in fact, the recommended limits for an older person are the same as the limits for that of a younger person (Lang et al a, 2007). Government policy does not specifically tackle alcohol misuse amongst older people, although the CMO was considering an investigation into whether there should be specific alcohol guidelines for older people this is yet to be completed. More stringent guidelines on alcohol consumption are recommended for over 65's and practitioners perceive the need for age specific approaches (Wilson et al, 2013a). Newcastle City Council is adopting the reduced limit recommendations for older people over the age of 65 years

although routine enquiry about alcohol does not appear to be mainstream practice.

2.7 Alcohol screening

The purpose of screening is to identify high risk individuals for a disease or condition (Bell, 1999). Screening can enable identification of those who exhibit risky or hazardous drinking behaviours and direct them to services thereby contributing to the potential reduction of all alcohol related harm whilst offering advice and education (WHO, 2002). The desire to mitigate alcohol use has led to a plethora of alcohol screening and brief interventions. These tools have been designed for both ease of application and to be cost effective (Derges, 2017). The NHS Health Check is a public health programme aimed at preventing disease (Daly et al, 2017). Preventative approaches can be cost effective in reducing risky drinking especially when applied as part of a routine screening procedure in primary health care settings. The Government's Alcohol Strategy (DoH, 2012) stated the requirement to include alcohol identification and any subsequent brief advice needed within the NHS Health Check for adults from age 40 to 75 for the first time from April 2013. Local authorities however, have a duty to offer the NHS Health Check to eligible people, with Public Health England supporting approaches that prioritise invitations to those with the greatest risk (Daly et al, 2017). As the NHS Health Check is a public health programme aimed at preventing disease, people with previously diagnosed vascular disease or conditions such as chronic kidney disease, coronary heart disease, diabetes, hypertension, heart failure, atrial fibrillation, transient ischaemic attack, peripheral arterial disease, stroke, or is currently being prescribed statins for the purpose of lowering cholesterol are

excluded from the programme. These individuals should already be receiving appropriate management and monitoring through existing care pathways. This consequently could result in older people not being screened for alcohol use as they are more likely to already being currently treated for one of the listed conditions.

There is a lack of evidence from non-health care settings and social care where the implementation of appropriate interventions has had mixed results. Barriers have included a lack of skills and knowledge, lack of training, attitudes to alcohol use by health professionals, queries as to the appropriateness of use in community settings.

Alcohol use in older people is generally accepted to be less prevalent than in younger groups (Dawson, 2009) but this could be due to poor detection coupled with the reluctance of professionals to screen and refer older people on to treatment services compared where required, to that of younger people (McInnes & Powell, 1994; Johnson, 2000; Kaner et al, 2001). While younger people are often stigmatised for their drinking habits, a silent story is evolving among older people (McVeigh, 2013). Hoec and Vanhall (2012) have termed this the hidden or silent epidemic highlighting that about two thirds of alcohol use among the older population remain undetected. Alcohol concern (2011) state that many reasons have been suggested as to why older people's drinking has received relatively little attention, including the preoccupation in much of the media on younger people's drinking behaviours in towns and cities, while in contrast older people may drink in solitude in their homes. Older people in general are very private about their problems and less obvious in

their drinking habits (Ward, Barnes & Gahagan, 2008). Ling et al (2012) highlighted that alcohol holds an established role within British culture where it is associated with socialising, pleasure, celebration and escape from pressure with a shift away from drinking within leisure premises and an increase in home drinking. Alcohol use can be hidden by the normal ageing process making it difficult to distinguish between those problems that are alcohol related and those that are of a consequence of ageing (Herring & Thom, 1997). The traditional view that alcohol use is uncommon in older people means that clinicians fail to ask about use, to overlook and discount evidence of any such problem, this results in alcohol use disorders in older people going unreported (O'Connell et al, 2003; Lock et al, 2012). Smith and Foxcroft, (2009) state today's 50-60-year olds represent the baby boom generation which experienced young adulthood during the 1960s, a time of great social change associated with more liberal and permissible attitudes. This generation may be more likely to retain old drinking habits compared with previous generations whose formative years were associated with greater austerity. Research into substance use among older people in the UK has been highlighted as a significant gap with most of the evidence showing effectiveness of treating alcohol use disorders originating from the USA with much of that limited to white men in veteran's hospitals which does not translate to the population being studied within this thesis (Crome, 2000; Moy et al, 2001). By concentrating on problematic or alcohol use disorders the risks of alcohol consumption are easily overlooked, older people tend to be one of the least informed groups when it comes to units and drinking limits (Herring & Thom, 1997; Lock et al, 2012). Research has concentrated on identifying harmful and

dependant drinkers but has failed to examine the possibility that in some circumstances or contexts alcohol consumption at well below the recommended levels may carry risks for older people. Older people tend to show a higher blood alcohol level than younger people on drinking the same amount of alcohol. There is evidence for alcohol related harm at lower levels of alcohol intake in older drinkers compared with younger drinkers, for example increased body sway in an older person can be seen within a normal blood alcohol level (Herring & Thom, 1997; Moore et al, 2003).

Lang and Melzer (2009) state that studies of alcohol consumption can be particularly susceptible to bias as they generally rely on self-reported levels of consumption which tends to be inaccurate, and that problematic drinkers are less likely to participate. Data can be difficult to interpret and contradictory. However, Herring and Thom (1997) argue that the possibility of problem drinking must be part of the checklist for all those who care for older people so that assessment becomes the responsibility of all professional groups as the proportion of older people in the population increases. Use of alcohol in older people may be more common than previously thought but accurate detection is hampered by the absence of suitable screening tools (Hajat et al, 2003). In 1980 The World Health Organisation (WHO) expert committee stressed the need for efficient methods to detect people with harmful and hazardous alcohol consumption before health and social care consequences become pronounced. In 1982 the World Health Organization asked an international group of investigators to develop a simple screening instrument. Its purpose was to identify persons with early alcohol problems (Babor et al, 2009). Harmful and hazardous drinking is defined as a quantity or pattern of alcohol

consumption that places the person at risk for adverse health events (physical or psychological harm) (Reid, Fiellin & O'Connor, 2009). However, it is acknowledged that valid assessment of alcohol intake is complex, with older people being less accurate and less familiar with standard ways of reporting intake resulting in under reporting (Lang, Guralnik et al 2007a). Instruments used for detection have not been validated for use with older age groups and therefore may not have the sensitivity or specificity of a tool that is designed for that purpose (Lakhani, 1997; Bell, 1999). The standard methods used to screen older people have been developed for younger people with indicators typically focussing on work, family and neglecting responsibilities but older people are less likely to be employed or have familial obligations (Herring & Thom, 1997). Lock et al (2012) state that instruments to detect problem drinking generally perform well in older populations. Screening instruments could identify individuals at an early stage preventing morbidity and mortality, reducing costs to the whole health care system and manipulating the person's environment by facilitating a move into supported housing even if they are not alcohol dependant but drinking in hazardous ways (Alcohol Alert, 2005).

The AUDIT (Alcohol Use Disorders Identification Test) and CAGE (Cut down, Annoyed, Guilty, Eye opener) have been reported as effective tools for the diagnosis of alcohol problems in older people (Ewing, 1984). CAGE is short, simple and easily applied and AUDIT has low sensitivity but high specificity, making it effective at highlighting those who present little or no risk and those who present a high risk (Fiellin, Carrington & O'Connor, 2000). CAGE is useful for identifying dependence where AUDIT is good at detecting harmful and hazardous drinking (Saunders et al, 1993; Berks & McCormick, 2008). These

are amongst the most widely utilised instruments used for alcohol screening in the older population (Johnson, 2000; Hirata et al, 2009).

The AUDIT was developed and evaluated over a period of two decades, and it has been found to provide an accurate measure of risk across gender, age, and cultures. AUDIT was found by a systematic review to be the best screening instrument for the whole range of alcohol problems (Fiellin, et al, 2000). A variety of subpopulations have been studied including primary care patients, emergency room cases, drug users, the unemployed, university students, elderly hospital patients and persons of low socio-economic status (Powell & McInness). AUDIT is an inexpensive and efficient tool which if to be used in healthcare settings in the future is an important factor (Pilpot, Pearson, Petratos et al, 2003). Lock et al (2012) highlight that whichever instrument is used general problems have been identified such as inaccurate self-reporting, staff embarrassment, poor use of the screening instrument by the professional and inaccurate patient history. The greater social stigma associated with older people's drinking may exacerbate under reporting or non-reporting of alcohol problems, this is especially true of women in mid to late life who may perceive pressure to present their drinking as moderate and appropriate in a way that men of the same age do not (Wilson et al, 2013a).

2.8 Alcohol use in older people

The North East of England has a significantly older population and higher rates of harmful and hazardous drinking than the rest of England coupled with being the poorest region in England with the lowest life expectancy at age 65 (Kaner et al, 2001). The prevalence of increased risk drinking in England in 2016 was

26% of men and 12% of women. This included 5% of men and 3% of women whose drinking could be categorized as 'higher risk' (defined as over 35 units for women and over 50 units for men). For men and women, the highest prevalence of people drinking above the low risk guidance was in 55 to 64-year old's. Almost a third (30%) of this age group drink more than 14 units a week (ONS, 2017a). In 2016, people aged 65 and over in Great Britain were more likely than any other age group to have drunk alcohol on 5 or more days in the previous week (24% of men and 12% of women) compared to 3% of men and 1% women aged 16 to 24. Of the English regions, 40.4% of drinkers in the North East "binged" on their heaviest drinking day (ONS, 2017a).

Ageing populations mean that the number of older people with alcohol use disorders is also set to increase (Mirand & Welte, 1996; Johnson, 2000; O'Connell et al, 2003). There is some evidence that today's older people may be heavier drinkers than previous generations. The General Household Survey (ONS, 2008) has shown that an increasing proportion of older people (over 65's) in Britain are drinking above recommended levels. In 1984 12% of men and 3% of women rising to 25% in men and 5% in women by 2008 are drinking above recommended levels of men not regularly drinking more than 3-4 units of alcohol per day and women not regularly drinking more than 2-3 units of alcohol per day (ONS, 2008; Simmell-Binning et al, 2009). It is estimated that 3% of all older adults consume excessive amounts of alcohol and 10% have an alcohol use disorder or related problem, an estimated 1.4 million people aged 65 and over exceed recommended drinking limits (Moos et al, 2009; McVeigh, 2013).

Older people are more likely to suffer from health problems, bereavement or social isolation and they use medications to a greater extent than younger individuals (Wilson et al 2013b). Herring and Thom (1997) observed that the predicted increase in the population of those aged 50 years and over will mean that even if the prevalence of excessive alcohol use stays at the same percentage this will be the same percentage of a much larger population. Far from alcohol misuse diminishing in the older population it seems it is set to rise if the drinking patterns of younger adults continue into their older years (Alcohol Concern, 2011). The report 'The Invisible Addict' (Crome et al, 2013) states that although there are no older people specific cost related data, providing treatment to 10% of the population who have an alcohol use disorder in the UK could reduce costs by £109-156 million each year. Bryant and Giyeon (2013) indicate that alcohol use is the primary substance of use in older people; it is pertinent for a greater understanding of alcohol use among older people; to allow more individuals to be identified and treated. Wilson et al (2013a) highlight that older people's drinking is regarded as subject to particular stigma which means it is likely to increase the isolation they already suffer disproportionately.

Heavy drinking among older people is likely to be more widespread than dependant drinking coupled with a rise in life expectancy within this population group, attention to older people and alcohol misuse is warranted (Mirand & Welte, 1996; Johnson, 2000; O'Connell et al, 2003; Wilson et al, 2013). Alcohol and drugs are amongst the top ten risk factors for mortality and morbidity in Europe, and substance misuse by older people is now a growing public health concern (Public Health England, 2016). McVeigh (2013) reported increased

alcohol related hospital admissions for the over 65's by 62% with alcohol related deaths within the 55-74 age group being the highest in the UK. Between 2002-2012 hospital admissions for those aged 60-74 for mental health and behavioural disorders due to the use of alcohol had risen by 150% from 3247 to 8120 (McVeigh,2013). Wilson et al (2013a) highlight that alcohol consumption can have a greater impact on physical and mental health at lower levels of consumption in older people than it would in early adulthood.

There is a lack of knowledge regarding alcohol use amongst the older population (Ward, Barnes & Gahagon, 2008; Blazer & Wu, 2009; Lock et al, 2013). UK surveys on alcohol consumption have historically failed to include older people or if they have included older people they have not included over 75-year olds (Lanhani, 1997; Gilhooly, 2005). Alcohol consumption amongst older people is rarely considered problematic at either the individual or public health level (Gilhooly, 2005). Given that a third of older people develop problems with alcohol later in life there are good reasons for targeting older people (Council for Scientific Affairs, 1996). Wilson et al (2013b) state that in England 28% of men and 14% of women over 65 years of age drink alcohol more than five times per week, they claim that more research needs to be conducted in order to gain a detailed picture of alcohol consumption in older people. It is time that excessive drinking in older age is recognised as a growing and serious problem and that appropriate and effective preventative and treatment services are made available (Smith & Foxcroft, 2009; Wilson et al, 2013b).

The National Health Service has so far failed to develop models to address the needs of older people with substance use problems. The planning and provision of services is characterised by a disturbing silence. It would seem that the most significant advance in highlighting the need for assessment and treatment of excessive alcohol use in the older population has been the publication of the second report of the UK inquiry into mental health and wellbeing in later life (Age Concern, 2007). This report draws attention to several areas including the high alcohol related death rates in the 55-74-year-old age group, the need to pay closer attention to invisible groups, detection, treatment and referral irrespective of age (Age Concern, 2007). Wilson et al (2013a) argue that heavy drinking in older people can be effectively addressed with preventative approaches particularly screening and brief interventions.

Serious medical disorders among older people who use alcohol are much more common than older people of a similar age who do not drink alcohol (Peele & Grant, 1999). Health services need to improve their provision of age appropriate screening and treatment services as at present many of the preventative and treatment services are targeted at younger people and their binge drinking behaviours (IAS, 2009). Appropriate screening is difficult to plan if the numbers of older people using alcohol in the population is not known (McInnes & Powell, 1994; Gilhooly, 2005; O'Connell, 2009). The health of the baby boomers (those born from 1944-1964) is of concern to policy makers because of the cost to the NHS of treating and caring for large numbers of older people when the tax paying base of younger people is shrinking by comparison. High rates of comorbidity with physical and psychiatric illnesses mean that older heavy alcohol users are liable to be frequent users of health

facilities and services (Johnson, 2000). Recognition and treatment of alcohol problems in the older population are likely to become increasingly important as the older population increases (Johnson, 2000; Gilhooly, 2005).

Age related changes in body composition in older people mean that a higher blood alcohol concentration level is achieved from the same amount of alcohol in a younger person (Herring & Thom, 1997; O'Connell, 2003). This is due to a greater physiological impact from a decrease in lean body mass and an increase in body fat leading to high levels in the bloodstream after a standard dose (Resnick et al, 2003; Simmell-Binning et al, 2009). Low reported levels of alcohol problems result in an underestimate of alcohol misuse in older people despite the rates of illness among alcohol users being higher than in the nondrinking population of a similar age (Lakhani, 1997; Johnson, 2000). Alcohol use in older people has an altered clinical presentation to that observed in a younger person. Older people present with a mix of symptoms but where alcohol consumption is lower, and where dependency symptoms are less severe but physical complications are more severe (Hirata et al, 2009). Health problems such as falls, malnutrition and insomnia are all exacerbated by alcohol use but can easily be masked by the natural ageing process (Resnick et al, 2003; Hirata, 2009; Simmell-Binning et al, 2009). The relationship between alcohol and development of diseases such as cancer, heart disease, dementia and Parkinson's disease depends on the relationship between the genetic makeup of the individual, the length of time and volume of alcohol consumed. Excessive consumption over a five-year period increases the risk of psychiatric problems, depression and dementia by up to

five times (Resnick et al, 2003; Hirata, 2009). This is likely to place an increased demand on health services (Johnson, 2000).

Several risk factors have been highlighted relating to alcohol use in older people including social withdrawal, family history of alcohol use, depression, smoking, male gender and stressful psychological events (Hirata et al, 2009). Poor health itself has been cited as a reason for a decrease in consumption but as the research highlights the level of consumption does not necessarily need to be high for there to be an adverse effect (Mirand & Welte, 1996). Older people are more likely to suffer chronic health problems, bereavement, isolation and the use of medication than younger adults and these health and social care problems may lead to increased alcohol intake to self-medicate or cope (Weyerer et al, 2009; Wilson et al, 2013). Ward, Barnes & Gahagan (2008), state that older people's drinking is affected by their personal, economic and social circumstances. It has been highlighted that late onset drinkers (those where alcohol use has only started later in life) use alcohol to cope with the stresses associated with old age, 70% of late onset drinkers could identify the stressors whereas only 25% of early onset drinkers (those who start drinking at an early age, usually with a genetic or biological susceptibility to alcohol use disorders) were able to report one (Rosin & Glatt, 1971; Zimberg, 1974).

The relationship between social contact and alcohol may be particularly relevant for older people moving into retirement communities such as sheltered housing accommodation. Schutte et al (2003) state that loss of support over the long term due to loss of occupation, income, skills or function

can lead to isolation and loneliness and may affect alcohol use. Although generally retirement brings about a reduction in income which could lead to a reduction in alcohol consumption, some dependant drinkers may choose to reduce food intake or paying of bills to sustain a level of alcohol consumption. Retirement also allows individuals more opportunity to drink including through the day (Gilhooly, 2005). Not all older people enter retirement in good health and alcohol may be used to self-medicate against pain or insomnia (Lang, Wallace, Huppert et al, 2007). Alcohol disorders can easily manifest during a bereavement episode either grieving the loss of a loved one or a life once known (O'Connell, 2003). The line between social and moderate drinking, excessive alcohol use and physical dependency is unclear (Resnick et al, 2003). For many older people daily alcohol use is considered the norm and is very much socially accepted (Resnick et al, 2003). The reasons older people give for their drinking are not well reported (Lader & Steel, 2009). Wilson et al (2013a) state that it is important to understand why older age groups are drinking more heavily and to consider why responses to public health messages may be weak.

There are many types of older drinker emerging from the literature including early and late onset and intermittent drinkers (Resnick et al, 2003; Simmell-Binning et al, 2009). Those with early onset have a continuing problem with alcohol that reaches into later life but developed in younger years. Those late onset drinkers who begin problematic drinking later in life quite often in response to traumatic life events such as the death of a loved one, pain from illness, or retirement. The third category is that of the intermittent drinker who uses alcohol only occasionally, sometimes to excess, they may have periods

of abstinence but then start drinking again (Moos et al, 2009; Simmill-Binning et al, 2009). Both late onset and intermittent drinkers have a higher chance of managing their alcohol use if they have access to appropriate treatment highlighting the importance of screening within this population (Tricehurst, 1990; IAS Factsheet, 2009; Joseph Rowntree Foundation, 2009).

2.9 Successful ageing

The emergence of the life course as a construct has led to the understanding of people having biographies (Murphy, 2010). In 'The Seasons of a Man's Life', Levinson (1978) documented the life journey of a group of men over many decades to present a picture of the life course transitions experienced and although this now reads as a retrospective representation it was at the time almost a picture of the recent past. A life course approach looks back across an individual's life experiences for clues to current patterns of health (WHO, 2000). It places the person in their cultural context with the ability to focus on total life experiences (Slota, 2003). Both the past and present experiences are shaped by the wider social and economic context, with critical periods of growth and development forming a cumulative experience rather than a linear passage through discrete life stages (WHO, 2000; Murphy, 2010). The narration of a story covering a whole life course is an intimate exchange; it can convey life lessons and link the events and stories of the past to the current day. You can see the consequence of earlier actions (Villar, Faba & Celdran, 2013). Successful ageing is the outcome of the individual's development over the life course, the ability to grow and learn by using past experiences to cope with the current circumstance (Satiene, 2015). People adopt many roles, often

ones which conflict, during their lives and have many life transitions; the life course aims to give a portrayal of the ageing process while being sensitive to the history of the person including the social and contextual position (Murphy, 2010).

The WHO (2000), argue that it is the quality of life that should be considered and the uniqueness of the older individual rather than the chronological age of life expectancy and reference to older people in homogenous terms. If early life events are important for social scientists to predict individual outcomes in later life then the ability of older respondents to recall with good accuracy, events that occurred many years ago is of importance. It could be said the more salient an event the more accurately it will be recalled (Havari & Mazzonna, 2015). However, the continually changing needs of the older generation and the diversity of those needs should be occupying the minds of professionals and researchers alike. Whilst longevity is something to celebrate, the proportion of those of a working age is shrinking whilst those of a pensionable age is increasing. While a larger population can increase the size and productive capacity of the workforce, it also increases pressure and questions the sustainability to provide social services such as education, healthcare and housing (ONS, 2017). The low priority afforded to the inclusion of older people in research studies as part of the planning and development of services often means that they have little opportunity to influence and shape policy and practice (Fudge, Wolfe & McKeivitt, 2007). Increasing the engagement of older people in research improves the generalisability of any research findings and can in fact inform best practice in the management of the growing older population (McMurdoe, 2011).

An individual can now expect a significant increase in the number of years they are likely to live but with a higher prevalence of non-fatal but disabling conditions. The multilevel factors that contribute to these conditions and the strategies that are the most effective and at what life stage should be focussed upon (Rose, 2016). Given the likely impact of these factors on health and social care services there is a pressing need to address substance use in older people to ensure that a full account of the required care needs can be made. If there is a shift from older drinkers to those who are older drinkers who are increasingly frail consideration needs to be given to what services might need to be commissioned that are not yet in place and in what proportion.

Without knowing what alcohol use is occurring currently can we assume an increase of people in sheltered accommodation will have alcohol use problems? This study will explore whether general assumptions from the main population can be transferred to the distinct population within sheltered housing. If as the General Household Survey (ONS, 2008) predicts we are to see an increase in the older population who drink then as health and social care needs increase there will be a shift from independent to more supported living.

2.10 Public health policy

A standard definition of public health is not easy to achieve as it is a discipline that is broad and often diverse. Public health is primarily interested in the health of populations and the prevention of ill health and disease. Definitions of health have been made often, for example The World Health Organisation

(WHO) defines health as “a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity” (WHO, 1946, p1). This definition has grown to include social wellbeing following on from the Ottawa Charter where there was an emphasis on not only the impact of individual’s behaviour as a precursor for health but that social, economic, political and environmental factors also played a part (WHO, 1986). The Acheson definition of public health most widely used in the UK. Acheson defined public health as “the science and art of preventing disease, prolonging life and promoting health through the organised efforts and informed choices of society” (Nutbeam, 1998, pg3). This is the definition that the UK Faculty of Public Health Medicine has adopted.

The Wanless Report (2004), highlighted that the individual should be supported to be fully engaged in any healthy lifestyle choice, shifting the focus from having healthy lifestyles done to them. Choosing Health (2002) addressed these recommendations by acknowledging the need for there to be a reduction in inequalities and an improvement in access to choices. The issue of health inequality is not new, with clear links between health inequalities, geographic regions, social class and ethnicity. The Acheson report (1998) highlighted this clearly using Dahlgren and Whitehead’s (1991) rainbow model of the multiple factors contributing to inequality. The Department of Health (1999) published ‘Our Healthier Nation’ as a response to the Acheson (1998) report which was pivotal in the influence and impact of public health, it stated clearly the work to be done and for the first time acknowledged public health as a key agent to facilitate change. The momentum of public health policy continued with the publication of the Marmot review, Fair Society, Healthy

Lives (2010) where the links between social position and poor health were clearly made. The lower the level of a person's social position the worse their health is likely to be.

There has been some focus on the effectiveness of behaviour change to help reduce health inequalities and there are a plethora of models and approaches to this. In order to understand behaviour, change the theory of public health should be explained.

Public health practice is separated into three distinct areas which are not stand alone but interrelate with each other. They include health improvement, health protection and service development, with these areas being underpinned by public health intelligence (Faculty of Public Health, 2010). These public health areas are detailed in Figure 1. Alcohol use fits well within each of these three areas, health protection as there are alcohol screening programmes to detect hazardous and harmful use and prevent injury, health improvement as there are targeted brief intervention programmes to educate and to reduce inequalities and finally service development as there needs to be cost effective, accessible treatment and prevention services.

There is an emphasis on population based approaches to health with an acknowledgement of the importance of increased individual engagement to pursue improved health especially in the context of lifestyle choices such as alcohol use, exercise, sexual health, smoking and obesity (Wanless, 2004). Public Health England, which was formed in 2013, aims to improve public health through the strengthening of local actions, supporting self-esteem and

behavioural change, promoting health choices and changing the environment to support healthier lives (DoH, 2013).

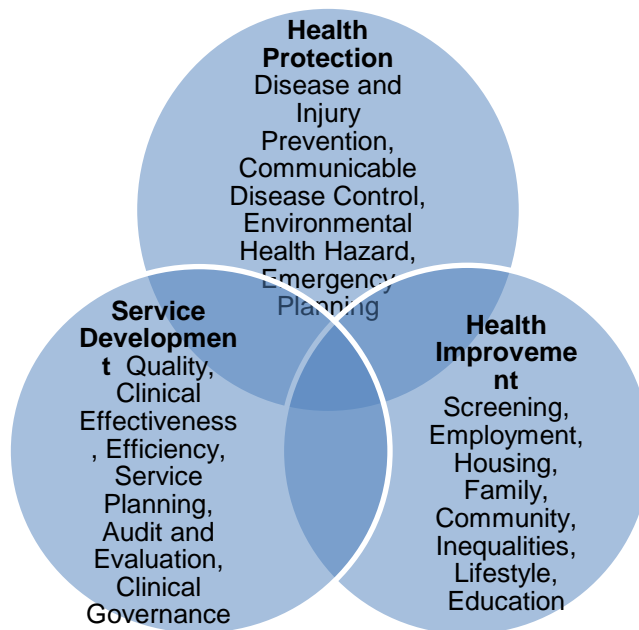


Figure 1 *Three Areas of Public Health Practice*

2.11 Health Improvement Models

The public health supported messages around alcohol use and recommendations for daily limits are important messages but unless individuals are made aware of their current usage via the undertaking of screening then many people will be unaware of their level of use and if as policy highlights that practitioners need to facilitate individual change, it is important to understand theories and approaches behind behaviour change, there are many theories on the subject. Many of these theories have overlapping constructs for example the social cognitive theory concept of self-efficacy (Bandura, 1986) overlaps with the construct of perceived behavioural

control in the theory of planned behaviour (Ajzen & Fishbein, 1980). Three models of health improvement will be discussed as they contribute to the knowledge around the fear of negative consequence as a motivator to change behaviour, the links between attitudes, intentions and behaviour and the anticipated risk of using alcohol. The models to be discussed are The Social Norms Theory (Perkins & Berkowitzs, 1986), The Theory of Planned Behaviour (Ajzen & Fishbein, 1980) and The Health Belief Model (Rosenstock, 1966).

2.11.1 The Health Belief Model

The health belief model focusses on how a person's beliefs impact on their behaviour (Connor & Norman, 2005). If an individual perceives a negative health outcome to be a threat or to result in the possibility of one occurring then the individual will take action to prevent that disease or outcome from occurring. The perceived threat is constructed from two aspects, the perceived susceptibility and the perceived severity. For action to be taken an individual normally experiences high susceptibility and high severity of the health outcome (Janz & Becker, 1984).

In terms of alcohol use individuals may not openly consider themselves to drink too much or that they may be at risk of developing alcohol related conditions and the model could highlight why people drink to harmful and hazardous levels and what perceived threat might alter this behaviour. The health Belief Model is shown in Figure 2. Important determinants in the adoption of health behaviour are the perceived benefits and barriers, for example with alcohol

use what is the health gain for reducing consumption and what might make that difficult to achieve. The influences such as the media with attractive advertising and the influence of peers and partners can affect what is termed as the cue to action, the stimuli that might trigger behaviour (Rosenstock, 1966).

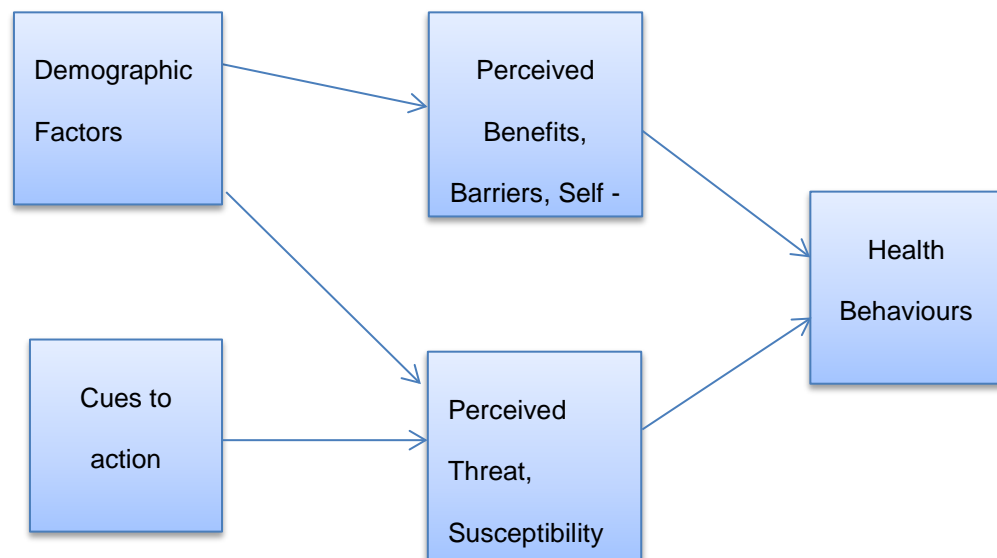


Figure 2. *The Health Belief Model*

The individual's belief about their ability to perform certain behaviour is commonly described as self-efficacy and includes the ability to engage in protective behaviour (Bandura, 1986). Although there is much support for this model it is not without criticism, the model does not take into account the social or economic factors which can influence behaviour (Roden, 2004). The model does not acknowledge behaviour intent only actual behaviours (Sheerna et al, 1999).

The health belief model assumes that behaviour is rational and thereby fails to take account of the impact and influence of emotion, compulsion and non-rational behaviour (such as drinking alcohol, which is basically a toxic substance to the human body, by choice).

2.11.2 The Theory of Planned Behaviour

A model of human behaviour that has been extensively utilised to predict health related behaviours such as alcohol consumption is the theory of planned behaviour (Cooke et al, (2017). The theory of planned behaviour focusses on a person's intent to behave in a certain way (Ajzen & Fishbein, 1980). The theory assumes that beliefs are the fundamental determinant of any behaviour and therefore any risk behaviour can be changed by altering the underlying beliefs. Intent and action are influenced by the individual's attitude towards the positive and negative aspects of a behaviour. What the individual perceives as the social norm or what other people might think about engaging in the behaviour type (Ajzen, 1988). Attitudes are beliefs that are accumulated over time, they can be formed by direct experience, external information or self-generation (Ajzen, 1988). If the individual has positive beliefs about the outcome of any behaviour then they are likely to have a positive attitude about the behaviour and vice versa (Ajzen & Fishbein, 1980). Social norms and what an individual believes others to be doing or what they would approve of, are key in health behaviour (Perkins & Berkowitz, 1986).

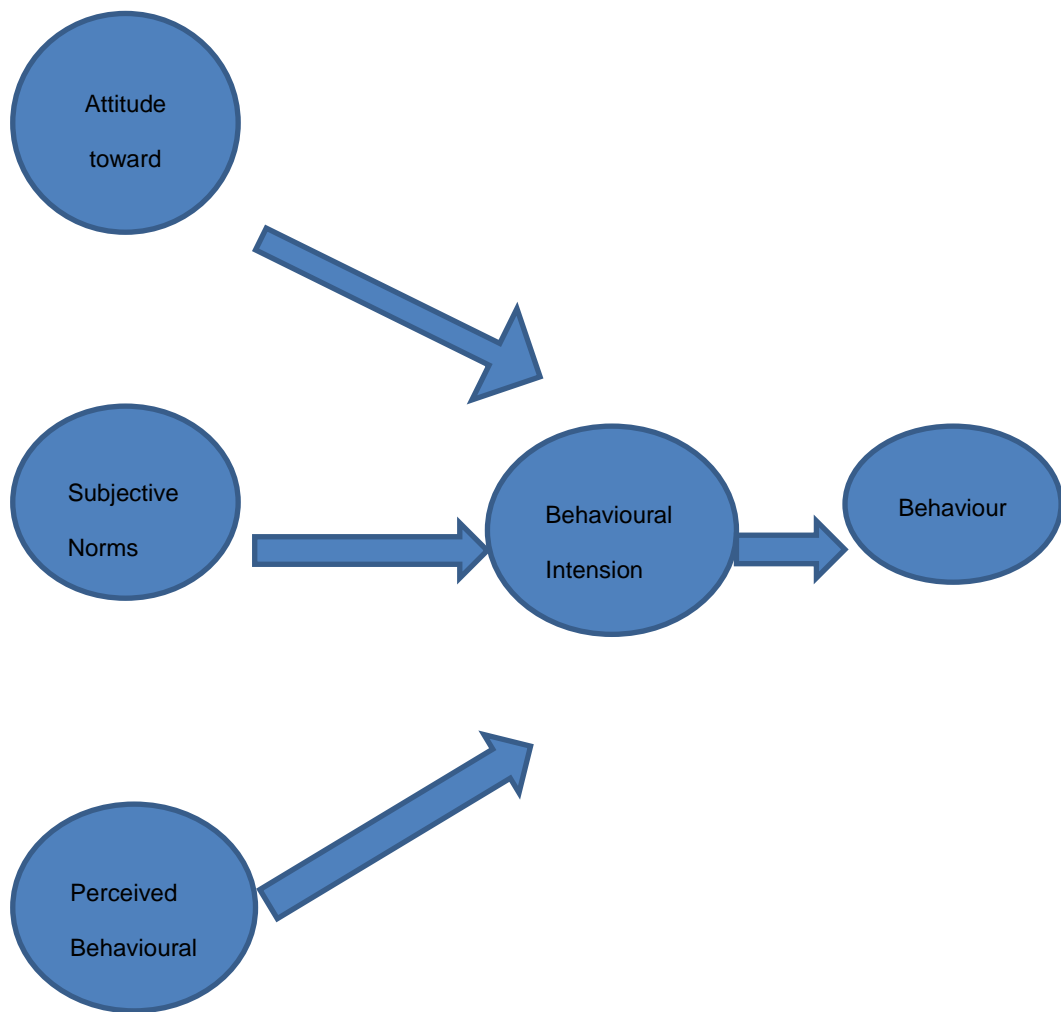


Figure 3 *Theory of Planned Behaviour*

For example, within alcohol brief intervention the individual and their drinking behaviours are placed in the wider context of the social norm for drinking behaviours. A weakness of the theory of planned behaviour is that it does not take into account for the influence of previous behaviours on future behaviour (Ajzen, 2002). Figure 3 demonstrates the Theory of planned behaviour. Interventions to reduce alcohol consumption should target attitudes, subjective norms and self-efficacy as a means to alter intentions (2017).

2.11.3 The Social Norms Theory

Peer influence and the role it plays in individuals decision making around behaviours is the primary focus of the social norms theory (Perkins & Berkowitz, 1986). This theory aims to explain the interpersonal and environmental influences to change behaviour. Much of the work carried out using the social norms theory has focussed on alcohol, illegal drug use and smoking (Berkowitz, 2005). A study of college students revealed a consistent pattern of misconceptions around the norms of drinking behaviours among their peers; students thought their peers were drinking higher volumes and more frequently than they were. The study purported the idea that by the correcting of the misconception might reduce the heavy drinking and related harm (Perkins & Berkowitz, 1986; Berkley-Patton et al, 2003). Social desirability and adherence to a gender role may affect how alcohol consumption is reported and shown; for example, women may under report their consumption while men may over report their alcohol use. There does need to be caution applied to the way men say they behave to how they do when relaying representations of their health (Robertson, 2003). All the models highlighted have both educational and conceptual merit and can make useful contributions to defining the determinants of health and inform the reasons behind behaviours such as alcohol consumption (Hancock, 1993).

Summary

This study will explore whether general assumptions from the main population can be transferred to the distinct population within sheltered housing. If as the General Household Survey (ONS, 2008) predicts we are to see an increase in

the older population who drink then as health and social care needs increase there will be a shift from independent to more supported living. The health improvement models may add clarity to the study aim, factors influencing the decision to drink.

Chapter 3 Research Structure: Study 1 and Study 2

3.1 Introduction

When carrying out research it is important that the most appropriate methodology is selected for the area under investigation (Baird, 1999). Every approach has both strengths and weaknesses and suits a context (Bell, 1999). Robson (2003) suggests that clarification of the research purpose assists in the matching of the aims to the methodology. The research purpose underpins the approach strategy and the type of information needed but the types of questions addressed and the evidence that is generated are also dependent upon the research design. The methodology defines how a researcher studies a phenomenon by the choices that are made when executing a research study (Silverman, 2005). Without a clear sense of purpose time and effort can be spent on areas that will not contribute to achieving the research aims (Maxwell, 1996).

There has been a longstanding epistemological debate about the nature and reality of knowledge (Patton, 2002). The positivist stance places emphasis on there being a single reality out there to be studied, captured and understood via hard data that can be counted and empirical evidence that can be subjected to statistical analysis. The interpretivist paradigm emphasises that reality is in the minds of people and their interpretation of that experience dependent upon social construction, the capture of people's opinions, feelings and practice informs understanding (Sarantakos, 1998; Wisker, 2001). The post positivist paradigm puts forward the position that it is the researcher's job to find reality in any phenomenon, whilst acknowledging that reality can never be fully

understood; as much reality as possible to be captured should be maximised (Guba, 1990; Denzin & Lincoln, 2003; Robson, 2003).

These theoretical stances are frequently aligned with either qualitative or quantitative methods. The positivist is associated with quantitative methods by which reality can be measured, tested and either confirmed or denied. There has been much debate as to whether these approaches are mutually exclusive or whether they can be used together to make use of whatever research tools are available in order to achieve the research aim (Lincoln & Guba, 1985; Tesch, 1990). The important thing is that researchers do not restrict themselves to a limited range of conventional research approaches or methods (Whitehead & Schneider, 2016). The combination of inductive and deductive reasoning makes the research outcome more persuasive than just words or numbers as multi methods provides a more in-depth data set (Allan and Skinner 1993; Yin, 2003). The notion of competing paradigms is viewed by some as outdated, paradigms should be complementary to allow for research to answer broader questions that span differing world views (Whitehead & Schneider, 2016). The research question for this PhD required investigation of both the numbers (alcohol use prevalence in Study 1) and words (the views of participants on alcohol use in Study 2).

For the purpose of this thesis the research aims were divided into two research studies. Study 1 involved a survey of the population in an attempt to gain prevalence of alcohol consumption. Study 2 involved interviewing a sample of the research population in order to gain an understanding around drinking behaviours. The aim of the research programme was to be able to develop

knowledge relating to alcohol use in the older population. The aims of each study are:

Study 1 to investigate the levels at which the sheltered housing population are consuming alcohol.

Study 2 to investigate the factors determining decisions to drink in later life.

3.2 Philosophical stance

The justifications of the choice of methodology reaches into the reality of what knowledge research can bring. It brings into question the theoretical perspective (Crotty, 1998). The way that the world is going to be looked at is determined by the epistemological stance adopted and the philosophical claims about the way in which the world is known to us; it involves the nature of knowledge and what we count as fact (Hughes, 1994). Epistemology is not always the starting point when considering real life issues; research generally starts with a problem that needs to be solved or a question to be answered. Each piece of research is unique and calls for unique methodology and we as the researcher have to develop it in order to allow us to achieve our purposes (Crotty, 1998). Methods are a means to an end however; technical procedures do not ensure the truth (Atkinson, 2013). The theoretical perspective is a way of looking at the world and making sense of it, to decide what kind of knowledge is possible. Figure 4 below provides a visual representation of the philosophical and methodological approach taken in Study 1 and Study 2.

	Study 1	Study 2
Ontology	Positivism	Relativist
Epistemology	Objectivism	Subjective constructionism
Theoretical Framework	Deductive	Interpretivism
Methodology	Quantitative	Qualitative
Method	AUDIT Survey	Interview, case study, life grid

Figure 4 *Philosophical and Methodological Approach Study 1 & Study 2*

3.2.1 Study 1

The quantitative methodology for Study 1 was that of a positivist paradigm, where there is a quest for objectivity and distance between the researcher and the researched. This approach tests theories and hypotheses and is used where there are numbers and values rather than view and interpretation, the approach is based on the belief of universal laws (Thompson, 1995).

3.2.1 Study 2

The qualitative methodology for Study 2 was that of the interpretivist; this is associated with qualitative methods such as interviews and observations which attempt to gather views and opinions (Patton, 2002).

3.3 Ontological considerations

Ontology is the consideration of the type of world to be investigated and the type of knowledge we can gather (Guba & Lincoln, 1990). I am a registered nursing sister with 20 years of experience, both hospital and community nursing. I work as a Health Improvement Practitioner (advanced) in The Wider Determinants of Health Team of the Public Health Team; housing and older people are part of my everyday work role. I therefore consider myself to be an insider researcher. As such I have had to consider the professional and personal knowledge and beliefs which I currently hold about the research subject. I acknowledge that I could potentially investigate and influence the practice situation such as the production of older person specific alcohol information. This experience means that I bring my own preconceptions to the research but rather than trying to step away from them they are embraced as part of the research experience.

3.3.1 Study 1

This research study comes from a positivist ontology that the world has a single reality regardless of any beliefs or perspective of the researcher. This means that any view held would not influence the responses given to the AUDIT survey.

3.3.2 Study 2

This research comes from relativist ontology that there are multiple realities for individuals and that this reality is subjective and dependent upon the cultural,

historical and social circumstances in which the person lives at the time of reporting (Guba & Lincoln, 1994; Crotty, 1998). The interviewing of a range of participants allows for the multiple perspectives and realities to be collated and the combined stories to make sense of the factors determining decisions to drink in later life. This is relevant for this study as the older people interviewed are from different generations with their own cultural, historical and social experiences affecting their views.

3.4 Epistemological considerations

Epistemology is the theory of knowledge; it is a way of understanding and explaining how we know what we know (Crotty, 1998). Epistemology provides the philosophical grounding for deciding the kinds of knowledge which are possible.

3.4.1 Study 1

This study assumed an objectivist approach takes the truth or meaning to always have been present but that a human applies a meaning to that truth. The understanding and meaning is objectified in those studied and if done correctly the objective truth is discovered. For example, a tree in a forest is always a tree regardless of whether anyone is aware of its existence; when it is discovered and is recognised as a tree we are only seeing what has always been there (Crotty, 1998). An objective point of view would not accept the interplay between the subject and the object; that meaning is not impacted upon by any kind of interplay between the two; there is a distance of influence from one to the other (Burr, 1995; Brewer, 2000).

3.4.2 Study 2

This study assumed a subjectivist constructionist epistemology where truth and meaning do not exist in an external world but are created by the subjects within them and understood by co-constructing knowledge and meaning (Guba & Lincoln, 1994; Crotty, 1998). Subjective epistemology acknowledges that researchers cannot be completely objective but understands the relationship between the researcher and the participant (Mills et al, 2006).

Meaning is constructed not discovered and therefore participants construct their own meaning relating to the same subject area resulting in different or common understanding. This relates to the participant and the researcher who both bring their own interpretation to the research situation, one in the stories being told, one in the understanding of them and this can impact and affect the outcome theory or observation. This involved exploring participant's life stories for the personal definitions of alcohol use and the justifications and reasoning for use. It also involved paying attention to my own social constructions influenced by my personal and professional background and experiences and the place of power in the process. As a health improvement practitioner specialising in housing and older people, including work around alcohol it would be impossible for me to separate myself, my prior knowledge and my assumptions from the phenomena. This epistemology acknowledges and recognises my own subjectivity on the research, its findings and the interpretations of those findings.

The interviews carried out for Study 2 were from a constructionist epistemology. The word constructionist suggests that meaning is not discovered but it is constructed via the knowledge of the individual interacting with their world (Crotty, 1998). The constructivist methods assume that multiple realities aim to provide interpretive understanding of the world to be studied (Atkinson, 2013). Constructionism encourages us to be suspicious of our assumptions about how the world appears to be and to challenge the view that conventional knowledge is based upon objective, unbiased observation of the world (Burr, 1995).

The ways in which we understand the world are historically and culturally specific, for example the notion of childhood has changed over time and therefore the ways we understand are culturally and historically relative as people construct knowledge throughout their daily and life time interactions between people in the course of social life (Burr, 1995). Within Study 2 the passage of time, historic and cultural shifts have an impact on the construction of people's reality about their alcohol use and the social constructs behind their behaviour. In this approach knowledge is created through the self-understanding of participants, and there is an emphasis on the importance of the collaborative relationship between the researcher and the subject in co-constructing data (Guba & Lincoln, 1994). The researcher's position must be made explicit to enable them to interpret the participants story credibly (Grant & Giddings, 2002). This highlights the need for an open mindedness and reflexivity in order to move beyond a strict problem focus to a more general exploration of social phenomena. The participants in this study are experts in

their own lives and my role was to investigate the socially constructed meanings that constitute their realities.

3.5 Theoretical perspective

The theoretical perspective informs the methodology linking closely to the ontology and epistemology to provide a constant thread throughout the research.

3.5.1 Study 1

The objective epistemology of Study 1 naturally leads to a deductive approach. The administration and the scoring of the AUDIT survey is the same for each participant, the influence of the researcher is minimal. The survey serves the purpose of collecting the data to be analysis without any interpretations placed upon the meaning of the answers.

3.5.2 Study 2

The ontology of Study 2 was concerned with the many meanings of the human world and the epistemology is that of constructionism; it is logical that the theoretical perspective underpinning this study is that of interpretivism. People actively construct their social world; they are not passive within it (Becker, 1970). The interviews within the study allow for participants to give their interpretation of alcohol use in their life time thus giving multiple interpretations of and perspectives of that same activity. The interpretivist paradigm seeks to understand people's behaviour and their interpretation of the world they live in, the understanding of situations from the individual perspective, the interaction

between people coupled with the historic and cultural framework (Cresswell, 2009). This research is looking at the factors determining decisions to drink in later life, the data collected directly from interviewing older people, to gain insight to their life course and therefore it is situated in the interpretivist paradigm.

3.6 Ethics

The research was completed through the collection of alcohol use survey data (Appendix 1) and in-depth interviews in order to be able to explore the research phenomena. The data included demographics of age, gender, and alcohol consumption information as well as detailed personal historical social information and identifiable data from the life stories.

Research on human participants necessitates regulations especially if it involves sensitive information. At the time of starting this research I was employed within an NHS hospital trust and therefore although the alcohol survey data collection would not be collecting any personal identifiable information other than gender and age, and I would not be accessing any patient medical records; I took advice from the chair of the national NHS ethics committee on whether I would require NHS ethical approval as well as university approval (Appendix 2). The whole research project was described in detail to the chair via a series of phone conversations and email. I was advised that the research did not require NHS ethics. The research project was then subject to the university ethics process. University ethical approval was granted for the research. Written permission was also sought and received

from the housing provider to use their housing register in the research and to access the sheltered housing buildings (Appendix 3)

During the research process I followed ethical principles. This included a participant information sheet for Study 1 and Study 2 (Appendix 4 & Appendix 5), this was to ensure the participant understood the reason for the research, what the process would involve, how their data would be used, how their data would be stored and to inform them that they could withdraw from the research at any time, and a consent form for Study 2 (Appendix 6). This written information was provided via the postal survey so that the individual had the chance to read the information and keep it. This allowed for the individual to show the information to a relative or carer and ask any questions. The consent form was given to the individual for a second time at the time of the interview, they were asked to read and sign the form to agree to the interview being carried out, for the digital recording of the interview, the storage of the data and the future use of the data by the researcher. This ensured that the individual fully understood the purpose of the research and did not feel pressurised into taking part in the research.

The information collected in relation to the research was treated as confidential and was kept secure at all times in compliance with The Data Protection Act (1998). The surveys, interview transcripts and digital recordings were stored in a locked cabinet, one within the researchers place of work and one within her home. All of the participant information was anonymised ensuring that no one could be identified from the data. All names (both that of the participant and anyone else they mentioned such as neighbours or family members during the

course of the interview) were removed. Consideration was given to using pseudonyms but as the research involved both quantitative and qualitative data which would be coupled together (survey data and interview data from the same respondent) it was initially decided that a unique identifier would be used for each survey with the same identifier used for that person's interview, however as the research progressed and the sensitivity and level of disclosure from the interviews was discovered it was felt that pseudonyms were more appropriate for the interview data. No personal information that would allow the individual to be identified by a third party was transcribed (where they lived, current and previous locations, places they had worked). All data stored on electronic devices was password protected and where this was not feasible the devices were stored in a locked cupboard.

There were a number of ethical issues that occurred during the research study. The first was the location for the interviews to be carried out. It had been decided to interview the participants in their own home as they were older people who it was assumed many might have reduced mobility. Interviewing in an individual's home would normally be seen as placing the researcher in a vulnerable position but as the individuals lived in sheltered housing, they all had community care alarms installed. It was agreed with the alarm service provider that I would log my arrival at the building entrance and again at my entrance to the specific property. This second call was done in front of the individual so that they were aware of my checking in. I then logged my exit from the property. It was prearranged that a call would be made via the alarm system for a safety call to be made at one hour if I had not checked out by this timeframe. This arrangement worked well and resulted in me feeling very safe

in each interview with the added bonus of the individual being in their home. It also gave some reassurance that I was in the building on the individual's invitation and with the agreement of the housing provider. The fact that the interviews took place in the individuals home, placed them in a secure environment. They had the ability to ask me to leave at any point, or indeed to refuse me entry. It was anticipated that their home environment would be where they were most at ease, less likely to be disturbed and for any information given to be in the privacy of their homes.

An ethical issue came as result of the subject matter of the research. The survey asked about levels of alcohol use and as a qualified nurse and health improvement practitioner there was some debate about what information should be given to someone who had an AUDIT score which implied harmful, hazardous or dependant alcohol consumption. This was not only a research ethical consideration but one from my professional governance and Nursing and Midwifery code of professional conduct. In order to provide a consistent health improvement approach, I undertook training in alcohol brief interventions, I felt that this gave me an enhanced awareness of the type of conversation I might need to have with an individual with a positive AUDIT score. I had developed an older person's alcohol advice leaflet in consultation with an older person's focus group. Both of these actions increased my knowledge around alcohol use and when and how to give information. All of the interviewees were given one of the leaflets and offered brief advice based on their AUDIT scores at the end of the interview (Appendix 7). As the surveys were returned anonymously this was not possible for the survey population. This met the requirements for ensuring no harm was done in the course of the

research. It was declared that I was a registered nurse as well as health improvement practitioner and that if it was considered that they were at risk of harm from a safeguarding point of view that I would need to contact another agency such as their GP. The information was given at the end of the interview so that it was not perceived as part of the research or a research intervention. The brief advice took place with the digital recorder turned off to reinforce the fact that it was not part of the research. Having the discussion about the audit score and brief intervention at the end of the interview removed this risk of the interviewee altering the information they shared based on new knowledge being received. It also ensured that the individual was left knowing what their score meant for them and some information on guidance on what steps to take if they wished.

3.7.1 Validity and Reliability

In the natural and the social sciences reliability and validity are essential to the integrity of research, however traditional methods employed for ensuring the reliability and validity of the research are not always the most appropriate for social sciences (Glazier, 1992). Within qualitative research reliability is taken as the degree to which different observers assign data to the same categories, or that the same observer assigns the data to the same category on different occasions (Hammersley, 1992). Validity refers to the rigor of the research processes and the trustworthiness of the research findings (Roberts & Priest, 2006). There are four concepts that can help to establish trustworthiness; they are credibility, transferability, dependability and confirmability (Guba & Lincoln, 1985).

3.7.2 Credibility

Credibility is an evaluation of whether or not the research findings present credible conceptual interpretations of the data from the participant's original data (Guba & Lincoln, 1985). The most appropriate test of credibility for qualitative research is that the findings are recognised as true by those who participated (Olivier, 1982). Within this research the interviewees were asked if they wanted copies of the transcribed interview and those who did were asked if they agreed with the data collected. This allowed for the interviewee to correct any data that they felt was not accurate, or to add additional information. This then allowed for the data collection to be credible.

There were two data collection methods within the research, survey data and interview data. These data sources were assessed against each other to cross check the data for bias and accuracy. The survey data was attached to the paperwork of those who were interviewed, this allowed the interviewer to see the alcohol use declared on the survey and compare to the declared usage through the course of the interview. As the survey data was a self-declaration of alcohol use it was important to ensure credibility by errors in reporting due to the participant responding with what they think is the ideal social response rather than their own experience (Kirk & Millar, 1986).

3.7.3 Transferability

Transferability is the degree to which the findings of the study can apply or transfer beyond the original study. This included consideration of the transferability of the approach used as well as the wider findings. The

supervisory team were involved in adding a level of credibility and transferability to the research by checking that the research process was clear enough for it to be followed easily. This involved discussing transcripts, themes, concepts and the developed model with the supervisory team. Ideally this would mean that the process used could be replicated and transferred to another area of study or to an additional research population. With the quantitative data this would be tested by the process of coding and analysis being followed and the same results being achieved.

3.7.4 Dependability

Dependability is the evaluation of the quality of the processes of data analysis and theory or concept generation. To ensure dependability the interviews were transcribed verbatim and were offered to the interviewee for confirmability. Transcripts were analysed using framework analysis and biographical narrative. This allowed for concepts to emerge and show clearly in the direct quotes from the interviews into the framework against each interviewee. A mind map was drawn to capture from the framework the 'why' of drinking and these were then reduced to smaller concept maps. The maps were then referenced back to the transcripts and where the context was altered in perspective or did not reflect strongly in the direct language of the interviewees then the concept was either revisited or in some cases removed for the main findings. This process ensured that the interpretation of data and the development of concepts were clear. The quantitative data was checked for errors at every stage with a clear process documented at each stage of analysis.

3.7.5 Confirmability

Confirmability is the measure of how well the findings are supported by the data collected. If the audit trail of the data collection is clear enough another researcher should be able to follow that process to arrive at a similar conclusion with the same data in the same research setting. The audit trail for this research includes the completed survey papers, the coding book, SPSS analysis sheets including the manipulation of the data, interview topic guide, life grids, the typed interview transcripts, the framework sheets, mind maps and documented model development stages. This offers a clear sequence to the process.

Chapter 4 Methodology and results for Study 1: A quantitative exploration of alcohol use

4.1 Introduction

The aim of Study 1 was to investigate the levels at which the sheltered housing population were drinking. There were anecdotal reports of high levels of alcohol use among the sheltered housing population and it was the first aim of this research to establish the actual level of alcohol consumption rather than accept anecdotal reporting. The quantitative methodology for Study 1 was that of a positivist paradigm, where there is a quest for objectivity and distance between the researcher and the researched. This approach tests theories and hypotheses and is used where there are numbers and values rather than view and interpretation, the approach is based on the belief of universal laws (Thompson, 1995). The analysis of the data is from the numbers presented and nothing more than this.

The sample was surveyed using the Alcohol Disorders Identification Test (AUDIT) 10 question tool, as the literature review demonstrated it is one of the assessment tools validated for use with older people. The summative scales when totalled gave an AUDIT score which denoted lower risk (0-7), increasing risk (8-15), higher risk (16-19) and possible dependency (20+) of alcohol consumption related harm (Saunders et al, 1993). The scores 16-20 were merged for this study to avoid possible identification of the participants as the numbers were potentially very small. The study was also not looking at the issue of dependency specifically but alcohol use overall. The high-risk score became 16-20. The 0-7 score is defined as lower risk as there is evidence that

no level of alcohol use is without risk entirely, this is particularly true for older drinkers (Holley-Moore & Beach, 2016). Analysis via SPSS was carried out on the data to assess the relationship between the gender and age categories of the sample on the outcome of the AUDIT scores.

4.3 Method

The quantitative methods used in this study enabled the gathering of data on prevalence of alcohol use in the population sample. A survey of a single north-east housing provider's sheltered housing population was carried out using the AUDIT tool (Alcohol Use Disorders Identification Test) (Barbour, Higgins-Biddle, et al, 2001). AUDIT is a method of measuring a person's risk from alcohol related harm which goes beyond just measuring consumption as it also measures frequency of alcohol use and the effect of alcohol use. Surveying allows for data to be comprehensive and detailed to enable mapping (Denscombe, 2007). The survey itself is a research strategy not a research method, the method itself is dependent upon the research population, timescales, budget and the research question (Polit, Beck & Hungler, 2001).

4.3.1 Inclusion criteria

Postal surveys were sent to the population sample who met the research criteria. Those who had dementia, a brain injury, confusion, lack of capacity or those who were seriously or acutely unwell were excluded. Those participants, who, at any time, did not meet the inclusion criteria, were removed from the study. The exclusion criteria were shared with Senior Sheltered Housing Officers as they had direct access to client records and an excellent

working knowledge of the tenants so could easily remove residents who did not meet the criteria before research packs were delivered. The names of the residents were not given to the researcher at the time of the postal survey.

4.3.2 Sampling

The sample for this research was a convenience sample taken from the largest sheltered housing provider in the north east; four additional housing providers were approached to be included in the study but declined the invitation. Information relating to the population sizes within all the sheltered housing providers was obtained from the local authority. In order for the research to be generalisable to the wider older population residing within all supported housing environments the sample size is crucial as the study may have too few participants (underpowered) which would mean that the risk that any outcome occurred due to chance would be higher. Sample size estimation is an important concern for researchers and it is often ignored or misunderstood (McCrum-Gardiner, 2010). The number of participants should be sufficient to be worthwhile but should not be so high as to involve unnecessary recruitment (COREC, 2007). The population within the sheltered housing accommodation used within the study was 982 properties (it should be noted that some of the properties may have more than one individual residing in the property). However, at the time of the research a number of the sheltered housing blocks were undergoing significant renovations which resulted in the residents being moved to alternative accommodation. Although the buildings were still registered as sheltered accommodation they were removed from the research leaving the total number of properties at 680. This could have dramatically

affected the completion of surveys as it was not known at all times which apartments were vacated. It was not possible to check which of these 680 properties had more than one occupant as the population data was given on the lead tenant only rather than household members. The sample is a representation of the total sheltered housing population in the north east. It is acknowledged and accepted that the sample will never be an exact replica of the whole population but that it will closely resemble it (Hoinville & Jowell, 1978; Allan & Skinner, 1993; Knight, 2002). Nearly all quantitative studies can be subjected to a sample size calculation however it may be of little value in exploratory studies where scarce data are available, in this research a retrospective sample size calculation was completed (Jones, Carley & Harrison, 2004).

The sample was recruited from the sheltered housing register. The Sheltered Housing officers were given the exclusion criteria (dementia, a brain injury, confusion, lack of capacity or those who were seriously or acutely unwell) and a list of addresses was produced with those meeting the inclusion criteria. A postal survey pack including a covering letter, information sheet, AUDIT survey, prepaid envelop, information sheet for Study 2 and a consent form for Study 2 was delivered to each address on the inclusion criteria list by the researcher via Royal Mail during the winter months of the first year of the research. It was considered that this was a good time of year as the dark nights and cold weather might cause the old residents of the sheltered accommodation to remain in their homes, thereby increases the chances of them receiving and completing the packs. The use of Royal Mail was to remove the risk of the research participants believing that the research was

being carried out by their landlord which could lower the response rate. All the residents who were originally contacted were sent another postal pack as a reminder including a thankyou message if they had already completed the survey and encouragement to return if they had not. These reminders were sent out after eight weeks. The prepaid envelope included in the research pack was to a university mailing address. An opportunity was also given to complete the survey for husbands, wives and partners of those who agreed to interview for Study 2 who had not completed the survey via the post. As the address details given by the sheltered housing officers did not state whether there were more than one person living in the accommodation it was useful to be able to collect additional survey data at the point of the interview.

A postal AUDIT survey was utilised to reach as many of the population as possible. Each participant was sent the same survey to complete and return allowing the answers to be aggregated across the sample (Hoinville & Jowell, 1978). Consideration was given to completing the survey face to face due to the sample population being over 55 years old but was discounted as an option. As the research topic (alcohol use) was potentially sensitive it was considered that a more accurate recording would be given away from the researcher. The potential sample size was much larger via postal survey as there were not the time constraints of face to face surveys. Consideration was given to the presence of the researcher during a face to face survey causing bias to the participant's response and that they may not answer honestly (Hoinville & Jowell, 1978). The postal survey gave participants the opportunity to consider the questions in their own time, in private and give a more precise answer. The aim was to achieve the highest response rate while

acknowledging the reliance on the participant completing and returning the survey with only written instructions to guide them (Denscombe, 2007). The surveys were delivered on a Thursday as prior work has found that response rates are improved if participants have the weekend to complete the survey (Hoinville & Jowell, 1978).

The study achieved a 9.7% response rate to the postal survey. This resulted in a relatively low population sample (n=66). In order to check that the sample was large enough to detect differences a retrospective sample size calculation was conducted. The sample size calculation was completed using the population sample (680), the confidence level (95%) and the margin for error (5%). The ideal population sample size was calculated to be 246, much higher than the 66 responses achieved. However, this does not invalidate the research. It should be remembered that the data achieved was from a group that had not been looked at before (older people living in sheltered accommodation).

The postal survey pack sent to each resident included a covering letter signed by the researcher and with the contact details of the researcher (address and telephone number), a participant information sheet, the AUDIT survey, instructions for completion and an addressed, stamped, return envelope. The pack also contained an information sheet and a consent form for Study 2 with a request for the resident to complete and return if they were willing to agree to an interview. Consent prior to posting was not obtained, as consent was understood to be gained upon the participant completing and returning the survey. The survey responses were returned directly to the researcher via the

university postal address. The researcher then coded the data making it amenable to statistical analysis via the statistical software package SPSS (Allan & Skinner, 1993). The research pack was piloted with five older people who were outside of the study population to check that the information sheets were understandable, were in the right size font and that the language used was appropriate. The only changes made following this were to the font size, which was increased. An example of how to complete the survey was included at the top of the survey itself. There was no assumption made that the individuals would know how to complete the survey. The pilot allowed for any areas of confusion to be ironed out before being printed and distributed to the research population. As the survey being used was AUDIT the questions themselves were predetermined but the supporting materials and instructions had to be tailored to the older research population.

4.3.3 Coding the Data

The AUDIT survey collected closed data. This included questions where there were either a number of responses (never, monthly, 2-4 times a month, 2-3 times a week, 4 plus times a week, never) and a simple response (yes/no, male/female). Closed questions such as this are normally easily transferred to a numerical format. For example, 'yes' would be coded as '1' and 'no' would be coded as '2'. In the example with multiple response choices each response would have an allocated code. When coding data it is crucial to be consistent in your approach. An example of the code book can be seen in appendix 8. There were no open-ended questions within the AUDIT survey. In addition to the survey data the client's age and gender was also collected. The actual age

of the person was asked for in order to facilitate correlation analysis as asking for age in a category would not have supported this type of analysis. Before entering the data into SPSS for analysis a code book was developed. This was a summary of all the instructions used to convert the information obtained from the individuals into a format that SPSS could understand. To develop the code book decisions were made about the defining and labelling of each of the variables and assigning numbers to each of the possible responses. The code book was kept safely stored throughout the research process so it could be referred back to, after a length of time, and still makes sense. An example of the coding used is shown in Figure 5. Within the code book each question from the AUDIT survey was written out with each possible response listed underneath with a code allocated to each response.

How often do you have a drink that contains alcohol?

1 = Never

2 = Monthly

3 = 2-4 times a month

4 = 2-3 times a week

5 = 4 or more times a week

6 = No response

Figure 5 *Examples of The Codes Allocated to The Variables*

Each returned survey was assigned a unique ID number. This number followed the individual through to the second study if they consented for interview along with a pseudonym. By placing an ID number on the survey at the point of return it ensured that all completed surveys were included. This ID would also help to unravel any problems should they occur, with the analysis. The number process ensured that there were no client details other than age requested, keeping the survey anonymous.

Once the code book was completed a data file was created using the information prepared in the code book and the survey responses. The data was then checked for errors as an incorrect entry could affect the statistical tests run.

4.4 Analysis

The analysis of the survey responses was done in two ways, the first with descriptive statistics, which provide a summary of the data, and then secondly using inferential statistics which try and predict outcomes. The descriptive statistics give results such as the number of missing variables, the mean, the standard deviation (the measurement of the average distance a value is to the mean), the range (the minimum and maximum points), the skewness (the clustering of data to either the left or right of the bell curve) and the kurtosis (which can indicate that there are too many cases in the extremes and would indicate a flat distribution). If there is a normal distribution (bell shaped curve) then the bulk of the data will cluster around the mean.

For some of the analysis the continuous variable was collapsed into distinct categories to facilitate analysis. In order to decide on the statistical test to use factors such as the type of question being asked of the data, the data type and the characteristics of the variables were considered.

4.5 Results

The descriptive statistics were used for both categorical and continuous data. Categorical variable (sex) was represented via frequencies as shown in Table 1.

The descriptive statistics via the frequencies show how many males and females responded to the survey and those where gender was not collected. The higher response rate from males in the research sample could reflect the view that men are more willing to discuss alcohol use than women. For continuous data such as age and survey score, descriptive statistics provide a summary of the mean, median and standard deviation. It is not necessary to show variable by variable and as demonstrated in Table 2 age and score have been analysed at the same time.

As Table 2 shows, there is a negative skewness for age (-.39). This means that the sample population skews to the right of the bell curve. This is expected as the population is older people. This shows that there is a not a normal distribution in the population sample. This affects the statistical tests that can be run.

Table 1 *Descriptive Statistics for Categorical Variable Sex.*

Categorical Variable Sex		
Gender	Frequency	Percent
Male	35	53.0
Female	25	37.9
Not answered	6	9.1
Total	66	100.0

Table 2 *Descriptive Statistics for The Continuous Variables Age and Score*

Continuous variables age and sex

	Min	Max	Mean	Std. Deviation	Skewness	Std. Error	Kurtosis	Std. Error	
Age	53	49	94	75.17	10.37	-.39	.33	-.28	.64
Score	66	0	20	3.11	4.6	2.05	.29	4.2	.58

Descriptive statistics were used to run frequencies for the survey scores, this showed that over 86% of respondents were in the low risk category of drinking (0-7 points) (Table 4).

Table 3 *Frequencies Survey Scores*

Score	Survey scores	
	Frequency	Percent
0-7	57	86.4
8-15	5	7.6
16-19	3	4.5
20-40	1	1.5
Total	66	100.0

This is a higher percentage than the UK older population where 80% of older people are in the lower risk group. 6% of those in this research sample scored 16+ on the AUDIT score compared to 3% nationally. Higher AUDIT scores do not always translate into higher risks of harm however. Descriptive statistics were used to run the frequencies on each of the 10 survey questions.

Q1. How often do you have a drink containing alcohol?

Table 4 *How often Do You Have a Drink Containing Alcohol?*

	How often do you have a drink?	
	Frequency	Percent
Never	25	37.9
Monthly	12	18.2
2-4 x a month	7	10.6
2-3 x a week	10	15.2
4+ a week	7	10.6
Not answered	5	7.6
Total	66	100.0

The frequency of drinking is lower than the UK average with 4+ times a week showing as just under 11% in this research compared to 17% nationally.

There should be a distinction made between the frequency of drinking and how much a person typically drinks, for example a person might drink once a week

to very high levels or five times a week at a lower level than the person drinking once a week.

Q2. How many drinks containing alcohol do you have on a typical day when you are drinking?

Table 5 *Number of Drinks*

How many drinks containing alcohol?		
	Frequency	Percent
None	25	37.9
1-2	9	13.6
3-4	9	13.6
5-6	4	6.1
7-9	2	3.0
10+	3	4.5
Not answered	14	21.2
Total	66	100.0

Q3. How often do you have six or more drinks on one occasion?

Table 6 *Frequency of Six or More Drinks*

How often do you have 6 or more drinks?		
	Frequency	Percent
Never	45	68.2
Monthly	7	10.6
2-4 x a month	3	4.5
2-3 x a week	3	4.5
4+ a week	3	4.5
Not answered	5	7.5
Total	66	100.0

Q4. How often during the last year have you found that you were not able to stop drinking once you had started?

Table 7 *Frequency of Being Unable to Stop Drinking*

How often have you been unable to stop drinking?		
	Frequency	Percent
Never	58	87.9
	2	3.0
Monthly	6	9.1
Not answered	66	100.0
Total		

Nationally 49% of higher risk drinkers say they failed to do what was expected but this research has less than 2% of the study who report this.

Q5. How often during the last year have you failed to do what was normally expected due to drinking?

Table 8 *Frequency of Failing to do What Was Expected*

How often have you failed to what is normally expected?		
	Frequency	Percent
Never	59	89.4
2-4 x a month	1	1.5
Not answered	6	9.1
Total	66	100.0

Nationally 24% of higher risk drinkers state they need a drink to get started in the morning but less than 2% reported that they needed a drink in the morning in this research.

Q6. How often in the last year have you needed a first drink in the morning to get you going after a heavy drinking session?

Table 9 *Frequency of Those Needing a First Drink in The Morning.*

How often have you needed a drink in the morning?		
	Frequency	Percent
Never	60	90.9
	1	1.5
Monthly	5	7.6
Not answered	66	100.0
Total		

Q7. How often during the last year have you had a feeling of guilt or remorse after drinking?

Table 10 *Frequency of Feelings of Guilt or Remorse*

How often have you felt guilt or remorse?		
	Frequency	Percent
Never	56	84.8
Monthly	3	4.5
2-4 x a month	1	1.5
4+ a week	1	1.5
Not answered	5	7.6
Total	66	100.0

7% of respondents stated that they had feelings of guilt or remorse after drinking this is usually more prominent in the higher risk and increasing risk drinkers.

Q8. How often during the last year have you been unable to remember what happened the night before because you had been drinking?

Table 11 *Frequency of Being Unable to Remember the Night Before*

How often have you been unable to remember the night before?		
	Frequency	Percent
Never	58	87.9
Monthly	2	3.0
2-4 x a month	1	1.5
Not answered	5	7.6
Total	66	100.0

A small percentage (3%) of respondents stated they or someone else had been injured as a result of drinking alcohol, this is a low result compared to the national average where 37% of higher risk drinkers stated that they or someone else was injured as a result of drinking alcohol.

Q9. Have you or someone else been injured as a result of your drinking?

Table 12 *Injured as a Result of Drinking*

Have you been injured due to your drinking?		
	Frequency	Percent
Never	58	87.9
Monthly	2	3.0
Not answered	6	9.1
Total	66	100.0

Q10. Has a relative or friend or a doctor or another health worker been concerned about your drinking or suggested you cut down?

Table 13 *Concerns Expressed by Others*

Have others expressed concern about your drinking?		
	Frequency	Percent
No	57	86.4
Yes	4	6.1
Not answered	5	7.6
Total	66	100.0

Via SPSS the continuous variable age was collapsed into three equal groups in order to facilitate analysis of variance. This altered the data from the specific age into one of three age bands. As the sample in this study had a non-normal distribution the non-parametric equivalent, the Mann-Whitey U Test, was used. Instead of comparing the means of two groups the Mann-Whitney U Test compares the medians. If there is a statistically significant difference in the scores between men and women explanation can be given as to the direction of the difference and which group is higher. The main values to consider in the output are that of the Z value and the significance level which shown as

Asymp.Sig (2-tailed). If probability value is not less than or equal to 0.05 then the result is not significant.

A one-way analysis of variance is similar to a t-test but is used when there are two or more groups (three age groups) and you want to compare the mean scores on a continuous variable (audit score). It is called the one-way analysis because only the impact of one independent variable is looked at on the dependant variable. This technique informs whether there is a difference in the groups but it will not tell you if there is a significant difference. The main pieces of information from this output are the chi-square value, the degrees of freedom (df) and the significance level (Asymp.sig.). If the significance level is less than 0.05 then there is a statistically significant difference in the continuous variable across the three groups. The mean rank tells you which of the groups had the highest overall ranking score.

The Kruksal Wallis test is the non-parametric equivalent to the one-way analysis of variance (ANOVA). This technique allows the comparison of scores on the same continuous variable for three or more groups. Within social research it is a common situation for the attributes that you want to measure not to be normally distributed (Pallant, 2007). Parametric techniques assume a normal distribution and therefore non-parametric techniques are used when there is a non-normal distribution and a small sample.

Two non- parametric tests were used to analyse data from Study 1 as the population sample did not have a normal distribution. The Mann Whitney U Test is the non-parametric alternative to the T-Test for independent samples. This tested for differences between two independent groups on a continuous scale. The outputs for this test are shown in Table 14 and 15.

Table 14 *Mann-Whitney U Test*

Mann-Whitney U Test				
	N	Mean Rank	Sum of Ranks	Median Score
Male	35	35.41	1239.50	4.00
Female	25	23.62	590.50	.00
Not answered	6			1.00
Total	66			1.00

Table 15 *Mann-Whitney U Test*

Mann-Whitney U Test	
	Score
Mann-Whitney U	265.50
Wilcoxon W	590.50
Z	-2.68
Asymp. Sig. (2-tailed)	.007

Mann Whitney U Test revealed a significant difference in the AUDIT scores for males (Md=4, n=35) and females (Md=0, n=25), U=265.5, Z= -2.68, p=0.007.

The mean rank scores for males =4.0 and females=.0 highlighting that males

had higher AUDIT scores. The age data were collapsed into equal sized groups with age ranges of ≤ 70 , 71-80 and 80+ and analysed by The Kruskal-Wallis test.

Table 16 *The Kruskal-Wallis test*

Age	Comparison of the scores for continuous variable age		
	N	Mean Rank	Median Score
≤ 70	18	34.53	6.00
71-80	18	28.17	2.00
81+	17	17.79	.00
Total	53		1.00

The Kruskal-Wallis test revealed a statistically significant difference in AUDIT scores across the three different age groups young old, $n=18:\leq 70$, middle old, $n=18:71-80$, old old, $n=17:81+$). $\chi^2(2, n=53)=11.07, p=.004$ (Table 18).

Table 17 *The Kruskal-Wallis test*

The Kruskal-Wallis Test

	Score
Chi-Square	11.07
Df	2
Asymp. Sig.	.004

The younger age group (≤ 70) recorded a higher median score (Md=6.0) than the other two age groups (71-80, Md=2.0, 81+, Md=0) (Table 17). This shows that the youngest age group recorded higher AUDIT scores than the other two age groups.

4.6 Discussion of results

The results show that males have higher AUDIT scores than females. Hirata (2009) highlighted being male as a risk factor associated with alcohol misuse in older people and this is reflected in the results of this study. Wilson et al (2013) stated that in England, 28% of men over 65 years and 14% of women over 65 years drink alcohol more than 5 times per week however the frequency of consumption may decrease in the older age groups which may be reflected in the outcomes of this study where the middle old and old old (71-80 and 81+) age categories reported lower AUDIT scores than the young old age (≤ 70). Crome et al (2013) state that in the past five years there has been a 62%

increase in the number of hospital admissions for over 65s and the alcohol related deaths remains highest in the 55-74 age group. This would be supported by the findings from this study as the ≤ 70 and the 71-80 age groups reported the highest AUDIT scores. McVeigh (2013) reported that the baby boomers, those born in the post second world war economic boom (1944-1964), are moving into old age and drinking to high levels compared with previous generations. This is of concern to policy makers as they face a large potential cost of treating large numbers of older people when the tax paying base of younger people is shrinking by comparison (Johnson, 2000; Gilhooly, 2005). Wilson et al (2013) state that women in mid to late life may perceive pressures to present their drinking in a way that is deemed appropriate and moderate in a way that men of the same age do not. This may account for men scoring higher on the AUDIT scale in this study.

4.6.1 Limitations

The main limitation of this study was the small sample size as noted in the discussion earlier. This could affect the reliability of results and the generalizability to the rest of the sheltered housing population. The small sample could have contributed to the non-normal distribution of the sample although that is more likely to be attributed to the age skew. The small sample may have had an impact on the normality of the data however it is likely, based on prior research; that older people do have a bimodal distribution to their drinking which would account for the lack of normality. This would mean that rather than the data having one peak for a normal distribution there are two peaks one for drinkers and one for non-drinkers.

There was an administrative error in the first batch of surveys that were delivered where the question asking for the respondent's age was omitted from the survey. This was remedied in the cases where the respondent also consented for interview and the age but it resulted in six cases where the age was not collected. The surveys for these respondents were still included in the analysis with age for these six cases classified as missing data.

There was one participant who was 49 years old included in the research. This could be viewed as altering the research from its focus on older people's alcohol use. However, this individual may have had a lower chronological age but they did meet the criteria for living in sheltered housing and therefore it is reasonable to conclude that they present as an older person. It was decided to include them in the sample as they were living within the sheltered housing environment with a similar lifestyle as many of their counterparts. This might have skewed the results as the lower age grouping was from 49-70 (a wide age range) however there was only one individual of this age. A breakdown of the recruited participants by age is presented in the Table 19.

4.6.2 Future research

Future work could be completed on a larger sample including those from all sheltered housing providers. There is potential for the study to be conducted on other types of supported housing such as extra care housing. The results from this study show that those aged up to 70 years of age and those who are male have higher AUDIT scores and therefore drink to higher levels than the other groups. What is missing from this information is the 'why' of drinking

behaviour. Study 2 of this PhD will build upon the finding from Study 1 to explore the reasons why older people drink alcohol via a series of in depth interviews.

4.7 Conclusion

This is the first study in the UK to measure the levels of alcohol consumption within the sheltered housing environment. The results have shown that for this sample who responded aged up to 70 years of age and those who are male were found to have the highest AUDIT scores. This information gives a valuable insight into the patterns of alcohol consumption within sheltered housing accommodation.

4.8 Chapter Summary

The findings from Study 1 showed that the sheltered housing population included are consuming alcohol at a level similar to that age group in any other housing environment (termed as general needs housing). What the results cannot account for are the anecdotal reports of high level drinking in this accommodation type. It could be argued that those in this type of accommodation are more visible members of society due to many of the residents having health and social care needs. This means that they do not to all intents and purposes lead private lives but are very visible. The findings show that males in the younger age group are drinking to higher levels than those in the two older age groups (71-80 and 81 plus). What Study 1 is unable to report on is the history of those screened. Two respondents disclosed that although they do not consume alcohol now, (they both scored zero on the

AUDIT survey); they did have an issue with alcohol misuse at an earlier point in their lives.

Chapter 5 Methodology and results for Study 2: A qualitative exploration of the factors influencing decision to drink

5.1 Introduction

The knowledge gained from the results of Study 1 frame and informs Study 2. Although the two studies are distinct pieces of work, Study 1 to consider prevalence and Study 2 to investigate factors determining the decision to drink, the mixed methods contribute to each other. Study 2 ran consecutively to Study 1. Alcohol related hospital admissions have risen by 62% and alcohol related deaths remain the highest in the 55-74 age groups (Crome et al, 2013). This mirrors the age group in this study who are consuming the highest levels of alcohol. It would be prudent therefore to look at the older population in more detail to see if the reasons behind alcohol consumption can be found. This would potentially ease the economical and societal burden placed on services by the increasing older population (Gilhooly, 2005).

Screening for harmful and hazardous drinking is useful and can direct people into the most appropriate treatment services but it can fall short in terms of the reasoning behind why people drink and the complexities of the motivators to do so. Although heavy drinking in older people can be effectively addressed with preventative approaches such as screening and brief interventions (Wilson et al, 2013); this thesis aims to go one step further to take a primary prevention approach. A primary prevention approach to alcohol use would facilitate the understanding of the paths leading to alcohol use in order to put measures in place to prevent it in the first place, rather than wait until there is harmful and hazardous drinking before any action is taken. Alcohol

consumption among the older population is rarely considered problematic at either an individual or public health level and yet one third of older people develop problems with alcohol later in life (Council on Scientific Affairs, 1996; Gilhooly, 2005). Previous research has highlighted the need for more research to be conducted in order to gain a detailed picture of alcohol consumption in older people (Wilson et al, 2013). Older people tend to be one of the least informed groups when it comes to units and drinking limits and although they may score low on a screening tool such as AUDIT, the consumption level may still carry risks for an older person (Lock et al, 2012). Study 2 aims to investigate the factors determining the decision to drink. This requires more than just a snapshot view of current drinking behaviours than screening alone can provide.

5.2 Method

The qualitative methods in this study aimed to collect data relating to the factors determining the decisions to drink in later life. Semi structured, life course interviews with a life grid were utilised for data collection.

The total number of consent forms received for interview was separated into male and female, low, medium and high-risk drinkers and young, middle and old age (<70, 71-80, 81+). The interviews were scheduled to take place in the interviewee's home unless an alternative venue was otherwise requested. This was so the interviewee could feel at ease in their surroundings during the interview. Conversely this also ensured safety for the interviewer working alone in the client's home. The participant's lived within sheltered

accommodation and therefore they had community care alarms fitted within the property; this allowed the researcher to report to the community care response centre at the time of entry and exit. If an exit call was not logged with the response centre at the one-hour point then contact would be made and if no response was heard from the researcher then assistance would be sent. Some of the participants had mobility restrictions and therefore being able to remain in their own home for the interviews ensured inclusion of those who could not travel. All the appointments were confirmed in writing. It was acknowledged that some older people might want family members present at the interview. In one interview the individual's daughter attended and at two others a family member was there to greet me and check their family member was ok and then removed themselves from the interview space. I did have concerns that the daughter being present might affect the information that was given to me but it did at times help as the daughter was able to assist her mother with dates and timescales. It was interesting however that the daughter disclosed that she did not know the majority of the information that her mother had given and thanked me for the family history, it is important to acknowledge that no data from anyone other than the consented participants was included in the research and that consent was gained from the interviewees for any family member to remain throughout the interview.

The interviews were recorded and transcribed verbatim. The semi structured format followed a life course approach taking the interviewee from birth to current day, the use of a life grid was utilised where the interviewee struggled to place their personal timeline. The life grid has been used in previous studies to collect retrospective data from older participants, it can reduce the worry

about recalling the details of their story correctly (Parry, 2009; Richardson et al, 2009). Personal events are often recalled in the context of external public events, older people have been found to construct their own biographies using a series of meaningful external reference points for example where was that person in their life stage during a royal wedding or a world cup win and therefore the life course approach to the interviews allowed the participants to follow this approach when recalling their own life events (Walter et al, 1987; Brown, 1990; Parry, 1999). The use of a life grid acting as an aide memoire gives some control to the interviewee over the data collection therefore altering the dynamic of the interview as the interviewee asserts some influence over their biographical accounts (Parry, 1999). The use of the life grid was utilised to aid recall and minimize the inaccuracies of memory this was particularly appropriate for the older research population (Holland et al, 1999). The anchoring of external events along with easily recalled demographic information allowed me to ask questions around alcohol use linked to personal events with ease.

Each interview in Study 2 had a topic guide (Appendix 9) which was adjusted after each period of analysis. The topic guide was initially influenced by the literature and with the life course structure of each interview. As the interviews progressed the framework became more of an interview guide and the original interview guide became redundant. The interviews were scheduled for 1 hour each and were recorded with a digital device. The interview times varied from 30 mins to 1 hour 40 mins. Prior to the interview starting the interviewee was given a second copy of the Study 2 information sheet (the first being posted out to them with the postal survey in Study 1). The Study 2 consent form was

read through with the interviewee and the chance to ask questions was given. The interviewee was asked to sign a consent form before the interview could begin. Each interview had an identification number attached to it. This corresponded to the identification number of that individual interviewees postal survey form. The interviewees were asked if they wished to receive a copy of the interview transcript. Seven of the 14 interviewees asked for a copy of the transcription. These were sent out to the interviewees and they were asked to confirm that the transcript was an accurate recording of the interview. All of the interviewees confirmed they were happy with the information collected in the interview and represented within the transcript. This confirmed that the interview had produced and recorded accurate information from the individuals.

Transcription takes time and can be tedious but it can allow you to become familiar with the subject matter. Professional transcription can be used but the negative of this is that the 'hearing' of the interview is lost and only the written word is used. Transcriptions of the interviews for this study were completed by the researcher to facilitate familiarisation with the data. The interviews were analysed using a framework approach, this is covered in detail in section 5.3.1 (Ritchie & Spencer, 1994).

A total of 11 interviews were completed initially. One of the interviewees requested to be withdrawn from the research. This participant agreed for the survey data to be included but for the interview not to be included in the analysis. This was confirmed to the participant in writing and the recording of the interview was deleted. A second recruitment phase was completed as

saturation of concepts had not been reached. The original respondents from Study 1 who had consented to be contacted but who had not yet been interviewed were contacted again to see if they would be willing to be interviewed. An additional six interviews were completed at which point it was felt that data saturation was achieved. The interviews systematically charted the life course journey of each interviewee within the topic of alcohol use but were open ended enough to allow the respondent to elaborate, an interview technique that requires practice in order to develop (Potter & Wetherall, 1987). Within the interviews various techniques were employed to achieve an atmosphere to encourage stories beyond the rehearsed disclosure, methods such as humour and self-disclosure which hopefully dispelled fears of being interviewed. The interviews were not about passing judgement or agreeing or disagreeing with the interviewee but to gather and report their views (Hughes, 1994).

5.2.1 Sampling

The sample for interview was taken from those participants who responded to the survey questionnaire from Study 1 and who consented to be contacted by the researcher. The Study 1 research paperwork included a consent form and information leaflet for Study 2 to be signed and returned with the AUDIT survey should the individual wish to be included. Each respondent was invited to attend an interview, there were 32 interview consent forms returned in total. It was expected that not all would respond to the interview invite or be available to attend once the interview was scheduled. Those who replied to the invitation

for interview were contacted and a time and date for the interview was arranged.

5.3 Analysis

5.3.1 Framework

The methodology is the plan of action behind the methods, it aims to describe, evaluate and justify the methods used. Framework analysis was developed by Ritchie and Spencer in 1994 as a method to manage and analyse qualitative data in applied policy research (Ritchie & Spencer, 1994; Smith & Firth, 2011). Framework analysis is of use when there is the potential to create actionable outcomes such as the potential changes to service provision for older people in relation to alcohol and housing (Ritchie & Spencer, 1994). Framework analysis sits within the broad family of analysis methods termed as thematic analysis seeking to describe and explain conclusions around themes (Gale et al, 2013). Framework analysis enables the researcher to maintain a transparent audit trail thus enhancing the rigor of the analytical process and the credibility of the findings (Smith & Firth, 2011).

Analysing data sufficiently to answer research questions can be a daunting task for the novice researcher but the interconnected stages in the framework approach describe clearly the processes that guide the systematic analysis of data from the initial management through to the descriptive to the explanatory accounts (Smith & Firth, 2011). Although it has been likened to grounded theory, framework analysis differs in that it is better suited to research where there is a specific research question (factors determining decisions to drink in

later life), limited time frame (part time, time limited PhD schedule while working full time) and a pre- designed sample (older people living in sheltered housing). The framework analysis may generate theories but this is not the main focus. The main aim is to systematically search for patterns in the data, to describe and interpret what is happening in a particular setting, in the context of this research asking older people living in sheltered housing about their drinking; in order to shed light on the phenomenon under investigation (Ritchie & Spencer, 1994; Gale et al, 2013). Framework analysis allows for flexibility during the analysis process allowing the researcher either to collect all the data and analyse it or to carry out data analysis during the collection process (Ritchie & Spencer, 1994). There are three distinct stages to the data analysis:

- 1) Data Management – becoming familiar with the data, reading and re-reading the transcripts, listening to the recorded interviews, identifying initial categories.
- 2) Descriptive accounts – summarising the range and diversity of the data, refining themes and categories, identify associations between themes until the whole picture emerges.
- 3) Explanatory accounts – developing associations and patterns within concepts, reflect on the original data to ensure the participant accounts are accurately presented and reduce the possibility of misrepresentation, seek wider application of concepts and themes.

(Ritchie & Spencer, 1994; Smith & Firth, 2011).

Framework analysis provides systematic and visible stages to the analysis process so it is clear how the results have been obtained from the data. This is particularly useful for part time students, such as myself; where other work commitments can make it difficult to re-engage with the data after periods of time away, although it could be argued that this prevents over immersion in the data. Re-reading the transcriptions of the interviews after a time away supports the phenomena to be considered as a whole, resulting in the meaningful movement backwards and forwards between the data and the links to the initial categories and the development of the conceptual framework (Smith & Firth, 2011).

The analysis of the interview data was iterative and began after the first interview had been completed and transcribed. The analysis started with the repeated listening to the digital recordings of the interviews to become familiar with the content and context as well as reading and re-reading the full transcripts. The two methods of familiarisation with the data highlighted differed aspects of interest from what was heard and what was read. The written word can be 'flat' and taken at face value whereas the replayed interviews evoked an instant recall for the researcher to the specific interviewee. This was also attributed in part to the interviewees 'voice' placing emphasis on words that the transcripts could not always capture fully. The fact that the researcher was able to become detached from conscious thought while listening to the interviews and purely enjoy the life stories encouraged and facilitated the linking of ideas. There was little effort required for the physical function of listening compared to that required when reading. This detachment of thought can benefit the development of concepts and themes.

Initial themes were noted as well as commonalities and differences across the interviews as well as within them. The framework was constructed to mirror the life course structure of the interview so that each interview was mapped following the same structure to support the ease of analysing the whole data set.

The transcripts were read one by one, line by line to find any references made according to the framework structure. The exact text from the interview transcript was transferred into the framework grid according to the ID of the interviewee (Table 19). The raw data was broken down into manageable chunks into the framework which provided an audit trail to identify who said what and in what context. As Table 18 shows the data from the interview relating to each framework heading was entered directly into the grid, this was not transferred as concepts or themes but as pure data under the framework headings to ensure that the analysis was grounded in the data.

During the course of the interview, the interviewee was not directly asked about alcohol as a separate issue but it was incorporated into the conversation along the life course. This was so the interview did not become instantly about alcohol. The subject area is often a difficult one for people to discuss and it was considered that the interviewees could be instantly on their guard if the first thing that was asked was directly about their alcohol use. The interviewee was asked questions about the age of their first drink, whether family members drank in the house or at the pub for example. It became part of the natural flow of the interview conversation.

Table 18 Excerpt of ID13 Framework

ID	Family	Family drinking	School / work	Own drinking
ID 13	I had 6 brothers and 1 sister, I've got 3 brothers now and a sister, I've got a daughter and 3 grandchildren, I'm single missed the boat, my dad worked in the ship yards and stuff like that and on the roads you know sweeping up and that for the council	He did used to like a drink. Mostly pubs I think. We used to go on trips with the clubs just once in a while she would never drink or owt (anything) He used to go out to the bars and used to drink in the house.	I got a job in the sweet factory I left school at 15. It was poor money like.	I can't say I really date now. Drank as a teenager I think I started drinking about the late 1950's the first drink I had was a port and lemon which I couldn't tolerate now. My first drink was on a dance trip. I've never been drunk in my life I lived dancing and I thought what have I been missing in my teens

During the analysis there was a strong sense of separation between those who drank alcohol and those who did not but it felt like it presented as an almost ethereal concept, there was a belief it was there but it did not present with strong evidence or substance. This heading was termed as resilience. To sort and synthesise the data a thematic mind map was created (Figure 6).

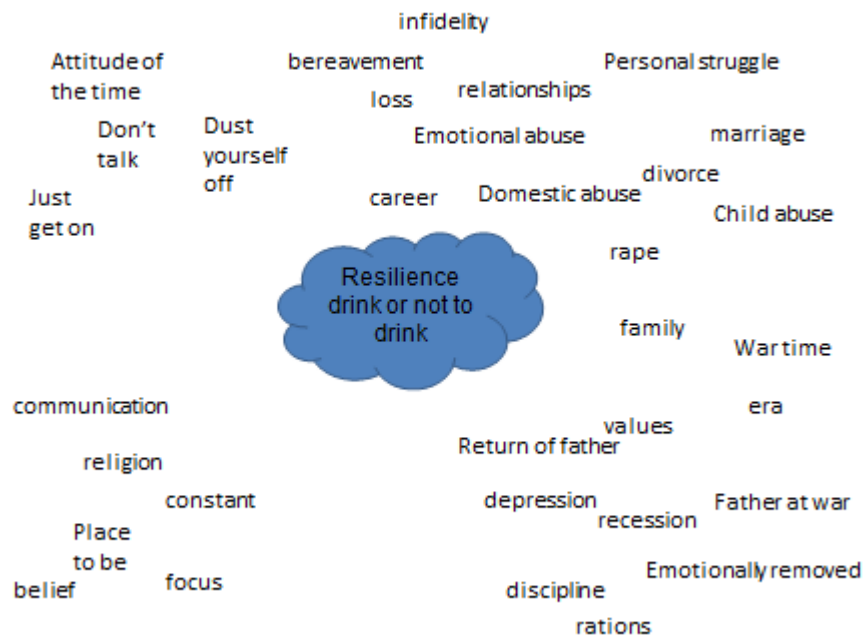


Figure 6 *Mind Map Resilience Drink or Not to Drink*

A mind map was completed with all of the concepts relating to the resilience of those who drank alcohol and those who did not. This highlighted that if consideration was given to each of the individual concepts in isolation they could in fact answer the question of resilience for both those who drank and those who abstained, they were to some degree interchangeable. Resilience it seemed could be used to protect from and promote the use of alcohol. A second map was created with the resilience factors only for those who did not drink. The aim of this process was to try and establish the factors that caused individuals with similar life experiences to either use or not use alcohol in their life and to explore whether there was a distinguishing experience or quality that an individual who did not drink held.



Figure 7 *Mind Map Resilience Non-drinkers*

The main concepts that emerged from the development of this map that was not present in the drinkers' map was the personal attitude and the sense of internal control. However, it still felt that this was not the full answer and that this map could be interchanged with drinkers. A third mind map was created with the emerging concepts relating to resilience for the interviewees who did drink alcohol. This map highlighted the importance of family and the impact of dysfunctional relationships on the resilience relating to the decision to drink. This initial analysis however did not capture the depth and brevity of the information captured from the interviews.



Figure 8 *Mind Map Resilience Drinkers*

There was no real sense of the interviewees within these mind maps and as a result the context of what was being said was almost lost. This was the absolute opposite of what the research was trying to achieve and the resilience was at that point metaphorically put to one side. There was still a sense of ‘something’ around control and strength but that in order to uncover it an analysis step back had to be taken.

As this study was asking the question of ‘factors affecting the decision to drink’ the ‘why’ aspect of the data was considered to be important. This was the essence of the factors determining the decision to drink. The framework was at this point scrutinised again and the entire ‘why’ elements of the interviews were taken from the framework and mapped. This felt like a much stronger analysis, with the concepts coming easily from the data. There were common

On some occasions the context and history of the interviewee's transcript rather than the direct excerpt, determined under which theme heading it should sit. The overarching theme headings changed once more to incorporate some of the attitude data that had been collected such as the relationship with alcohol, company/isolation, medication/mental health, housing, labels and definitions, emotional coping, work, and location. The transcripts were then returned to check the context of these higher themes. The continued returning to the original transcripts allowed for clarification that the analysis was in the participants own words and in the original context as stated in the interview. This meant that the meaning of the data was not lost in the researchers own translation and interpretation. At this point once again, some themes were discounted or merged into overarching themes. The framework, the mapping and the cross referencing of the data prevented the researcher's ideas, feelings and hunches taking over the analysis, it ensured that the views represented were strongly evolved from the original interviews.

Mind maps were drawn up for each theme at this point in the analysis. A total of eight minds maps were drawn up. Figure 10 shows the map for social contact. This theme would grow to include some elements from the choice map including concepts such as the use of social occasions such as weddings and Christmas to drink alcohol and the attitude taken towards not only alcohol but to the interaction with others.



Figure 10 *Social Contact Mind Map*

Figure 11 shows the merged mind maps of the family breakdown and domestic violence maps. The words in red originally came from the family breakdown map, the purple came from the domestic violence map and the black were those associated words that were best placed into this map. These two themes were merged into one as they strongly interlinked and the interview data highlighted that one quite often led to the other, this became the domestic violence theme. The theme of family however remained in its own right. The purpose of re-examining the concepts and themes was to describe and understand the phenomenon under study. The returning to the framework structure and the original transcripts assisted in the descriptive details and ramifications of the factors determining the decision to drink. This helped to determine whether there was sufficient data to support the research

interpretation and to see if further interviews needed to be completed to follow up any areas of inquiry. The analysis resulted in five themes that were factors in older people's decisions to drink. The five themes identified were mental health, domestic violence, family, work and social contact.

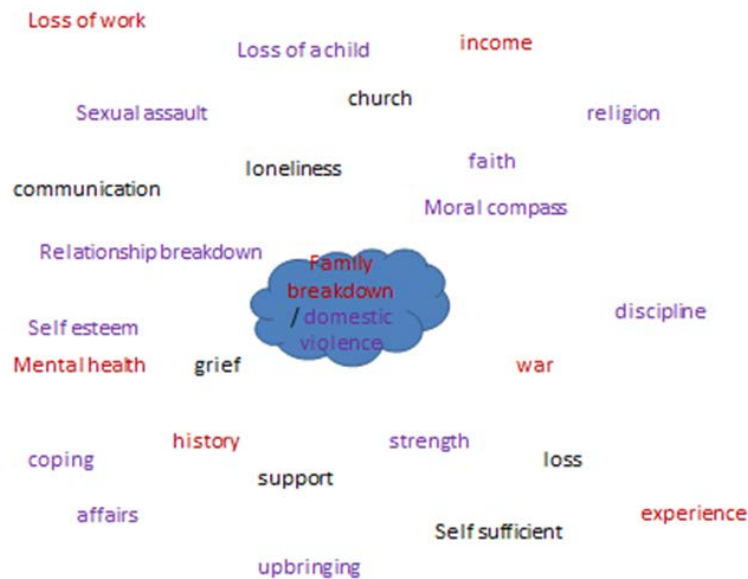


Figure 11 *Mind Maps Family Breakdown and Domestic Violence*

It was noted that housing had not presented strongly within the interview data to establish as a theme, a point worth noting given that the research population were in specialised housing.

5.3.2 Biographical narrative

On completion of the framework analysis five core concepts were generated but there was a sense that there was more to the data and that the full explanation to the research question had not been achieved. The framework

analysis felt like a superficial analysis which if left as it was would have given a level of explanation to the research question but it would not have presented a full or complete answer. As the interviews were completed with a life course approach (birth to adulthood) there was the luxury of being able to consider the retrospective influence of the person's whole life on the framework outcomes. Rather than a snapshot of the current day representation of alcohol consumption the life stories of the individual could be overlaid on the framework giving a depth and quality that was not achieved by the framework analysis alone. The biographical narrative was a rich addition to the research outcomes.

Researchers are becoming increasingly interested in the long-term impact of childhood events on the individual outcomes in later life. Child development features heavily in the research literature documenting clearly how early life can be considered a good predictor for health status in adulthood (Havari & Mazzonna, 2015). The biographical method has become an extremely significant approach to social research, it reflects the growing interest in the life course, an increased concern with the lived experience and how best to express and reveal that (Roberts, 2002). The personal and individual nature of biographical data allows for the expression of self by oral history, reminiscence, storytelling, life history and narrative providing insight into the individual perceptions and understanding of situations and experiences (Bornet, 2008). Biographical methods allow for interpretation of individuals lives and the accounts that they give of their past, present and future, it highlights what the individual sees as important, the individual is the creator of

meaning through a collaborative process of data collection with the researcher usually via interview (Roberts, 2002).

Life stories generally refer to real events and experiences often with the story teller being the only witness, this leads to researchers being pragmatic in their approach rather than a firm allegiance to realism (an objective knowledge and empirical basis for individual experience) or constructionism (the story and the researcher's interpretations are focussed on how the story was formed including the collaboration with the researcher). A pragmatic view would postulate that stories are collected and used in different ways for different methodological and theoretical purposes. The purpose is to gain insights into an individual's lives reflecting the wider cultural meanings of society rather than dwelling on the differences in methodological and theoretical assumptions. Theory should not flatten out the views of the individuals (Roberts, 2002).

In order to achieve a life course story, it is essential to have detailed data on the individual's life from birth to adulthood. This data is commonly collected retrospectively based on memory (Havari & Mazzonna, 2015). Memory can change according to the audience, the stimuli and the time of life but the story told as multi-dimensional remembering should be acknowledged (Bornet, 2008). The intimate detail of a life history gives the sense of knowing a life while acknowledging that there could potentially be disparity between the lived life and the told life (Roberts, 2002; Bornet, 2008). Errors in recall can occur especially if precise details such as when an event took place cannot be remembered, however modern survey techniques such as a life grid can be utilised as they minimise recall failure (Havari & Mazzonna, 2015).

The research population in this study are older people and therefore the need to reduce recall bias was crucial, it is acknowledged that bias may not be eliminated completely especially when there may be decades for the recall to span but there are methods to minimise any recall bias (Berney, 2003). The life grid is a useful tool for mapping important life events against the passage of time (Wilson et al, 2004). A life grid is basically a chart with rows showing the years in an individual's life and columns representing different areas of their lives (Richardson et al, 2009). Table 19 shows a section of the life grid used in the interviews for this research.

Recall can additionally be improved by the use of a temporal reference system such as an event calendar with flashbulb memories where extraordinary events become linked with the routine and mundane for example people tend to remember where they were when president Kennedy was shot or when Princess Diana died and these external and unusual events ground the persons own stories (Berney, 2003).

Often biography is constructed through reference to personally traumatic events and this is often dealt with in a very pragmatic way by focussing on the skeleton outline of their lives and not dwelling on what might be very painful experiences. The life grid can be used to help the individual identify a specific year and complete the story like a jigsaw where the picture gradually emerges (Parry, 1999).

Table 19 *Excerpt of Life Grid ID2*

Year	External event	Year of Birth	Family	Location	Occupation	Drinking behaviours
1918	End of WW1	1922	1 younger sister	Newcastle		
1930	The great depression					
1939	Start of WW2				1937 signed up for national service	
1945	End of WW2		Met his wife while serving abroad			
1948	Launch of the NHS					
1952	George VI died		Bought first house 1951			
1953	Elizabeth II coronation					

For these interviews, the topic of alcohol use could have been a sensitive topic to discuss in the personal context of their lives but as alcohol was discussed in the wider parameters of their life it had meaning without being a blunt and standalone subject matter. Alcohol was not placed in a specific column in the life grid, although via the consent for the study alcohol could have potentially been at the back of the individuals mind. It was an aim to gain a holistic insight into how the individual situated alcohol use in shaping the biographical narrative without assuming that alcohol took a dominant role. Life grids are typically printed on large A3 sheets so they can be seen easily. A life grid can assist in the pressure being lessened or removed from the individual to tell their story chronologically because as the grid is completed, the stages and sequences of life emerge. The life grid also acts as a prompt and tool for the researcher to place in context any events of the story told. It is useful in the context of focussing on historical events in an individual's life in order to enhance the exploration and understanding of the issues the study is seeking to illuminate (Richardson, 2009). The life grid makes the cross referencing of data easier for the interviewer and helps to build rapport between the interviewer and the interviewee (Berney, 2003). The life grid can anchor the narrative of an everyday life in a visual element of the life grid allowing for a cross referencing of data enabling an improvement in the accuracy of recalled data but it can also facilitate the release of additional information from a life story by juxtaposing detail from a memory from the same life period (Wilson et al, 2004). The life grid goes some way to rebalancing the power relationship with the interviewer relinquishing some control over the data collection allowing

the individual to assert influence over their own biographical account; it encourages the true voice of the individual

5.4 Results

Within this section the five main themes will be presented in detail including mental health, domestic violence, and family, social contact and work influence.

5.4.1 Mental Health

Within this section the elements of mental health from the data will be presented as well as some of the narratives of the older people. This highlights the ways in which mental health is talked about and the context in which it is placed for the interviewees. In many cases the stories surrounding the mental health create the picture and circumstance of alcohol use and its place in their lives at that time.

Mental health conversely was both a protective factor and a contributing factor in terms of consumption of alcohol in the research population. Ten of the 16 participants reported a history of a diagnosed mental health condition such as depression and or anxiety, all of these ten interviewees had received treatment, and many had experienced hospital admissions. The six interviewees who did not report a diagnosed mental health condition still referenced states of stress or anxiety but to a lesser degree. Mental health and associated alcohol use was complex in terms of the pathway to alcohol use and the definitive cause if any but from the interview data collected there were

a number of common elements including the use of prescription medication for a diagnosed condition, the role of parenthood, the ambition to be well again, managing loss and ability to cope. Each of these will be discussed in this section.

5.4.1.1 Prescription medication

For some, the fact that they had been prescribed medication was enough in itself to prevent the consumption of alcohol.

I ended up on tranquilisers for a while, for depression. I never thought of alcohol ever, well of course you can't have alcohol with them anyway. Mary

The fact that they had received medical advice was held in high regard and therefore there was little or no consideration given to going against medical advice.

[...] but you see even through the depression alcohol never entered my mind because in my sense you don't take drugs and alcohol. Albert

For those interviewees, where medication was not a protective factor there was a conscious awareness that it was far from ideal, an acknowledgement of being medicated and using alcohol not being a good way to function. Elsie acknowledged that although she thought alcohol helped deal with the breakdown of her marriage; with hindsight, she acknowledged that it did not actually help in the long term and that the reality of her situation was that she had to face the issues for a second time but without alcohol.

I told him he had to leave or I would call the police. I felt like it was a death. I had got married for life; he was the father of my children. I was on medication and I drank. I was on medication and I drank in the house. When I look back it didn't help. Elsie

For those interviewees who mentioned the use of medication and alcohol came to the conclusion that they had been self-medicating with alcohol and that adding prescription medication into the mix essentially resulted in being over medicated.

5.4.1.2 The role of parenthood

Some of the interviewees stated that their role as a parent during a period of poor mental health provided a focus that prevented the use of alcohol. The very action of providing care to a dependant and having a child that needed them was enough of a deterrent not to drink.

I had my daughter, and in those days, I would say I've got to cope with a daughter and I thought I had to concentrate on that. You got to think about the child. Mary

For some interviewees however, the breakdown of relationships that resulted in an altered relationship with their child acted as a contributory factor in their alcohol consumption.

....we still had contact with the kids and they had a couple of visits and they just cut off contact. It was horrendous. I drank again. It was my default mechanism. James

5.4.1.3 Ambition to be well

For some of the interviewees the fact that they wanted to experience a degree of recovery from their mental ill health prevented the consumption of alcohol. They relied on friends and family to support them, however for Elsie this was only after a prolonged period of using alcohol and medication to cope with depression.

I was in a pretty low place at that time, but I didn't use drugs or alcohol that time, I had friends and family who helped me out of the hole. Elsie

The absence of using alcohol to self-medicate resulted in other means of support being sourced whether that was family support or medication prescribed by the GP.

I had a nervous breakdown and ended up on Valium for about four years, I couldn't get off them, socialising and drinking was the last thing on my mind. Albert

Albert stated clearly that the main focus was to become well and that the use of alcohol in this instance was associated with having fun and being social, a potential distraction from mental health wellbeing.

5.4.1.4. Managing loss

For many of the older people interviewed, the need and ability to manage loss was factored into alcohol consumption. The term loss is broad and within this analysis covers loss of a person, self, place, memories and a life once known.

I connected alcohol with the good times, it connected with my family, the singing, the good times. James

James had moved away from family and although this had happened a number of years previously there was still a historical memory of where was considered to be home. The memories talked about were mainly from when he was a child but these held a strong emotional control over him.

I loved my husband for the age of 19, it didn't go away, it still hasn't gone away, it was true love but we never had a drink in the house. I still don't. Jean

Both of these excerpts feel very positive in terms of the loss experienced; the first from missing family, the second from bereavement however the first used alcohol to manage that feeling the second did not. Jean had lost her husband some years previously but still talked about him with a great deal of emotion. Her practice of no alcohol in the house was strongly led by the emotional contact she experienced with her husband. For some of those interviewed alcohol was used to block out the feelings of loss.

I drank to block out [a bereavement], it started as a drink to feel better, I thought it felt very good and very fast it increased. The

next morning, I thought how am I going to face the day? and so I would drink in the morning because I was trapped in a life I didn't want. Then it escalated to where I drank 24 hours a day.

Jackie

For Jackie the death of a relative caused the feelings she had towards her own life to surface, she was in an abusive, unhappy marriage and at this point there was a sense that death would almost be easier than dealing with her life as she saw it. It highlighted to her how trapped she was and caused her drinking to spiral to the point of addiction.

Looking back, I had depression and drank to mask it. I was drinking to cover my grief, the whole funeral for my mam is a blank. I can remember my dad but I can't remember my mam at all I got so drunk. James

James lost his mum and dad in close succession and this was a form of cumulative grief, where he did not fully recover or grieve his first loss before the second. This interview stated that drinking was his default behaviour to cope.

5.4.1.5 Ability to cope

For some older people their ability to cope determined the use of alcohol. It was both a protective factor and a reason to drink.

I have weeks where I don't drink and then I have a binge and that's when I'm not coping. I miss London. I drink to be social

and then I drink to cope, we call him Mr Bastard, even I don't like him. James

James stated that he did not feel he was a miserable drunk, that he created his own celebrations. This presented as a form of denial by the interviewee as he did not acknowledge the depressant effect of alcohol alongside the depression he already experienced. There was a view that he drank to be happy when this should be an intrinsic quality of the person. James was of the view that being happy via alcohol consumption would stop him thinking about whether he could cope emotionally with situations he felt to be a challenge to him.

Yes, the physical abuse wasn't too bad there were times where it tailed off but there were times when he was unhappy and I go to bed and I would end up getting two feet in the middle of my back and he would kick us out of bed and tell me to find somewhere else to sleep. It took me a long time to come to terms with this; he robbed me of my personality. That was when the drinking started. Jackie

When Jackie realised that she was in a physically and emotionally abusive relationship she found the reality too hard to face and drank rather than accept her situation.

The crutch had been thrown away, hadn't it? I didn't have no crutch at all did I? There was no help in them days. I went to Collingwood clinic at St Nics hospital. I think I was there for

three or four weeks. I would have been on medication but actually they gave us that thing I should never have had. Electric shock treatment. Yeah, I didn't really know what it entailed really, but it didn't do a lot for me. I think it only made us lose me [my] memory more than anything else. They used to say I wish you'd have a decent drink but I used to have a lime and soda. Peggy

For Peggy she had cared for her increasingly challenging disabled child without professional support. When the child was 11 years old Peggy tried to get help but this was in effect denied. Rather than drink to cope with the current situation Peggy's mental health suffered to the point of a hospital admission.

5.4.2 Domestic Violence

Domestic violence featured in seven out of the 16 interviews completed. The exposure to and experience of domestic violence was given as a reason to drink and a path to discover other means to cope with the situation.

5.4.2.1 Direct experience of abuse

For some of the older people interviewed their own experience of domestic abuse caused the use of alcohol in order to cope with the situation they found themselves in.

I just thought it was a horrible life. I was completely trapped. I had all the guilt feelings because my son wasn't getting what he should. He heard the way his father spoke to me. My son

and his cousin say they knew what I was doing, they knew I was drinking, they knew in my mug there wasn't tea or coffee.

Jackie

For Jackie she drank in order to escape from the reality of her abusive marriage. The emotional and physical abuse was still too much of an ordeal despite her son and his cousin being aware of her drinking and the reasons for it.

He drank a fair bit now I think about it, he started to get physically abusive about seven years into the marriage, it was drink related. I just put up with it, he blamed me but he used to gamble the money. I was on medication and I drank. Elsie

Elsie had a period of about one year where she drank and took medication to cope with the abusive nature of her husband.

I had a raging side to me about things that were done, not necessarily to me but to my mother by my father and its only in latter years I've come to understand this, her full life tret [treated] like, I don't know quite how to say this but like a door mat really, I suppose. Percy

Percy experienced a strong emotional reaction when talking about the treatment of his mother by his father. He stated that he never felt like he fitted in and was struggling to find a place where he felt at ease and used alcohol to

try and facilitate this. His family relationship with his parents was talked about with a sense of anger towards his father.

5.4.2.2 Alcohol as a cause of domestic violence

Some of the older people interviewed stated that their own behaviour was altered by the consumption of alcohol and that this had a negative impact on all their relationships.

In relationships and with my personality because when I had a drink I could get feisty and then in the morning I had to apologise for it. James

5.4.2.3 Alternative coping

For some older people who experienced domestic violence they did not use alcohol but made reference to other coping mechanisms such as family, inner strength and faith.

I was frightened to get up in the night in case I woke anyone up and I didn't feel I could just make a cup of tea. I had no control over what I watched on tv, you know I was a lodger really. I had inner strength, we never had drink in the house, I still don't. Jean

For George he had experienced his own father drinking to excess and this acted as a barrier to his own drinking behaviour. For this interviewee the idea of family was so strong based on his childhood experience with his mother that

he used this to support him in difficult times, his family, friends and the church became vital to him.

I met my first wife and we had two children and the second child was a daughter, my wife decided that she didn't want girls and she put her up for adoption. I didn't think she was serious. It is really difficult to give up a child. I let her take our son. I got custody of my daughter. Alcohol was never used to cope, never, I think it was family, I stayed with a cousin who I was close to but I think the main thing was my faith, it gave me strength. I have always been able to put my focus and strength in things and not wallow. George

For Anne she had been brought up in care, experiencing a number of abusive relationships in her quest to find a family. When she and her daughter were sexually assaulted her default was to take care of herself and her child by relying on herself only, she had never had anyone else before and so she just got on with things on her own.

I got giddy until a young lad took us home and he raped us. That's when I fell with my third child, he went with my daughter, my young daughter after, when he raped me, she was only eight. They arrested him there and then but he only got 11

months. I just got on with it. I didn't drink, I just focused on the bairn I was having. Anne

5.4.3 Social contact

The degree of social contact experienced by the older people interviewed varied. Many of them detailed the fact that most of their friends had died and so some of the social opportunities afforded them were from relatively new contacts within their accommodation. For some this was viewed as a positive outcome but for some it was almost viewed as unsolicited friendship.

*I've lost all my close friends as well which is unfortunate, I'm still here and most of them have had very little wrong with them but have gone. I'm the last man standing, there is no one left.
Albert*

For Kenneth he felt that because he was unable to serve in the forces in the war that he had little in common with those around him. He had assumed that he was different and would not fit in; he declined all offers of socialising.

It's not the same here because the neighbours used to know everybody. I keep to myself. They are very sociable people, they are about my age or a bit older, they keep themselves to themselves the majority, they do ask do I want to go and that, I just keep myself to myself, I just drink in the house. Kenneth

Brian had lived a life with over 30 years living abroad. He was not into football and did not like the pubs and clubs and so felt that the men who lived around

him were not the sort of people he would choose to socialise with over and above the fact that they lived in close quarters. He had a strong sense that his friends were still in the country he had lived for so many years. There was a huge cultural gulf that he seemed unable to negotiate.

Between you and I they aren't really my sort. I think I have a very particular type. I talk to my friends in Italy. I miss Italy very much. Brian

For some of the older people they embraced friendships and activities within the sheltered housing environment.

I like it here, I grow a lot of plants in my green house. I'm always busy doing things. I have lots of projects. George

I go to the bingo on a Wednesday night, I meet a friend and we go for out dinner and I see my daughter once a week. Once you got your confidence going out and going in a café on your own you sort of get pally with people. Mary

For some older people the best company was their family or just simply themselves.

I've always been a bit of a loner really, I've always had the girls and my lovely grand bairns [grandchildren] and great grand bairns. They say that they wish I would go and have a drink but I don't like the taste, never have. Peggy

Albert had friends within the housing environment but not the sort of friends he would go to the pub with, he would pass the time of day with them in passing.

I've got one or two but I don't go out with them. I think that's why I go to the pub to have a couple of pints, to watch the telly or the racing. I get in conversation with somebody when I'm there. I used to go to the club with a bit of entertainment like bingo or a singer or something but that was with my friends.

Albert

With each of the above excerpts there was not the sense that older people within this study drank alcohol due to a lack of social contact or due to being lonely, indeed some interviewees chose to be away from social contact when the opportunity to engage presented itself whether that was to have an alcoholic drink or not.

5.4.4 Family

The role of family for all of the 16 interviewees was a pivotal aspect of their lives either via the influences of family when they themselves were children or through their own experiences of relationships as adults (marriage, divorce, having children and bereavement). It did not initially show its importance however in the relationship with the factors determining to drink. Family as a social construct is complex and varied but even in its most dysfunctional forms it was still deep seated in each of the interviewees. When analysing the data at the framework level family did not present as a key topic, however with the overlay of biographical narrative from the interviewees, family became one of

the most interesting of topics. Without the biographical data the in-depth details of the interviewees would not have been uncovered and a level of context lost. The biographical narrative went beyond the snapshot of current day but gave situational and emotional context to the interviews and the survey data from Study 1. The research no doubt would have been interesting but it would have been a snapshot of current time rather than the build-up of the picture to the current day. Of the 16 interviewees seven of them were divorced, two of them more than once. By today's standards this does not seem exceptional but it was a surprising outcome given that divorce in this generation was perceived and portrayed as being unusual. Seven of the interviewees had experienced the death of a partner, this did not however appear to have a direct impact on drinking behaviours and it is not clear whether the death of a partner is experienced in the same way as the death of a parent. Of the 16 interviewees, three of them experienced the death of a parent when they themselves were still children and three experienced the divorce of their parents.

The experiences of family can be separated into four sections. The first being their own experiences as a child, including the impact, experience and influence of their parents and guardians. The second is that of their personal adult relationships, marriages and partners. The third is that of their own family in terms of having their own children. The fourth is the experience of loss of the chosen life partner and or parent.

5.4.4.1 Experiences as a child

The experiences as child influenced some of the interviewees in their use of alcohol. The family experience as a child provided the foundations for future

adult life with the development of values and beliefs, self-esteem and security. Three of the 16 interviewees were raised as children outside of the relationship with their parents. Fred had a very positive perspective on being raised by his grandmother.

When my mum and dad split up I went to live with my gran it was the best place to live. Fred

There was a sentiment that this environment offered stability that had been lacking with his own parents. This is a view that was also reflected with Kenneth who was raised by a couple who were not relations when his own father could not cope.

I got fetched [brought] up by another couple, call them auntie and uncle, they are dead now like, but they fetched me up, my real father couldn't look after me at that time. Kenneth

For both of these interviewees there seemed to be acceptance of the circumstances but set against a backdrop of war displacement the sense of somewhere to go appeared to be the priority. For Percy there was slightly different family focus, although this interviewee had a mother and father present there was the perception and belief that the relationship was not healthy and the positive family influence came in the form of a workplace mentor with whom he still maintained contact.

I think drinking is only the symptom of what is really going on internally, you know really because I've had a lot of demons to slay and a lot of things to face up to in my life. You know I haven't really had it that easy. I had a raging side of me about

things that were done, not necessarily to me but to my mother by my father. All the rest of it has just been a cloak I suppose you put on to wear. I don't think I've known anything other than disappointment. I'm still in contact with my mentor, he is 85 years of age and I phone him every evening to make sure he is ok. He is more of a father figure than my dad was. Percy

This interviewee had become an alcoholic and attributed this largely to the feeling of not fitting in or having a sense of belonging. This is a factor experienced by Anne who was raised within the care system from the age of three. This interviewee had a number of failed foster placements and as an adult a number of dysfunctional and failed marriages. It was as if she had no benchmark of family life to anchor herself to.

I got taken when I was three years of age into a children's home nobody wanted this, me mam had died, I didn't know her, me [my] father I didn't know until I was 11. I stayed until I was 15, I thought it was me home, I mean I got fostered out three times and I didn't like it. Anne

Many of those interviewed mentioned the use of alcohol within the family home but none of them detailed the use of alcohol in a destructive manor. Bob talked about the routine for his family to have alcohol with their Sunday lunch, behaviour that continued on to his own adult life.

We used to have a bottle of cider at home with Sunday dinner and I only drink cider now, that's why I say I'm not really a tee

totaller. I drink cider because that's what I was used to drinking.

Bob

For James the experience of alcohol consumption was closely linked to social gatherings and times of happy celebration. Indeed, this kind of drinking linked to the clear memory of times of celebration continued into his own adult life where when misusing alcohol, he created his own party, his private celebration.

Oh, they were big on socialising in the house round Christmas, big parties round the house, in the pub mum played the piano, the community was basically the pub. You know once or twice a week with all the aunts and uncles and we would all stand around outside with our hands out asking for packets of crisps.

James

The family celebration focussed drinking was also a happy memory for Elsie.

I can remember when I was younger they used to sit around the piano and have a sing song and my uncles used to come they would play cards and they would get a carry out from the club, a jug of beer and things like that. Elsie

For George the fact that his father misused alcohol had some influence on his decision not to drink.

My father was a gentleman alcoholic, he dressed in a shirt and tie, he wasn't violent or anything like that. None of my brothers

and sisters are big drinkers, I've never thought about it mostly because of my father being a drunk. George

Percy did not witness his father consuming alcohol despite the relationship between his mother and father being a difficult one.

I can honestly say really that I don't think I ever saw my father drink; he might have had a pint after work or such like but there was never any problem with that. Percy

For many interviewees early family life was difficult especially for those whose lives were affected by the war. Dot experienced the suicide of her father when she was aged 15 when she discovered him hanging in the washhouse.

We just got on with life. We never spoke about it [the suicide], we spoke about my father as my father and the washhouse was still the washhouse. We had to still use it and that's where he hung himself and we just went and did it, we just got on. He hung himself, his balance of his mind was gone from the war.
Dot

For Albert his mother was widowed as a result of the war and money was always tight as a result.

My mother was left a widow at 40-odd, she didn't remarry, she got 50p a week widows pension to keep us, we had no help.
Albert

For some of the interviewees the fact that their fathers were at war caused them to effectively live in single parent homes. George only had contact with

his father for the early years of his life due to active service. The relationship between his mother and father did eventually breakdown as a bi-product of the experience of war.

My father joined the army he must have been 15, he went to the First World War to the Battle of the Somme and he was a very young soldier at just 15 years of age. He met and married my mother and was with us for the first couple of years and then of course the Second World War started. He served in them both. My mother was left with five children when he was at war.
George

For Jackie the experience of war clearly changed her father's behaviour and she noticed a change on his return.

He wasn't strict but he was very organised, he was a lovely man, he never raised his voice, he didn't swear he was very organised. You had to polish your shoes and had to have breakfast, you had to look after your things. I've carried that all through my life. Jackie

This is an experience mirrored by George.

I remember his drawers, everything was aligned and every morning 6am there was a cup of tea, every morning. George

5.4.4.2 Adult relationships, marriage and partners

For many of the interviewees marriage was talked about with a degree of seriousness, a sense that it was not entered into lightly. Alcohol use did at

times impact upon relationships but there were cases where being in a strong relationship prevented the use of alcohol as there was appropriate support. For Jean she considered that marriage was until the death of her husband.

I was married until my husband died in 2004, it would be our silver wedding next year. I had 6 children, 3 boys and 3 girls, one was a step son but I brought him up from age nine. Jean

James had a difficult first marriage with alcohol causing arguments which led to the eventual breakdown of his marriage as well as the estrangement from his children.

I had met my wife when I was in the brewery for a year. I had a boy and a girl, I don't see them. We were together ten years. You could drink and drive and wherever you went they gave you a drink or two, you went to all the pubs. I was drinking heavily and it caused arguments. James

Within James's second marriage there was a less isolated relationship with a partner who was included in some of the socialising.

I met my wife and before I knew it I was in love and that was that. We were together 18 months before we got married, she was my life saver; she has been the best thing that has happened to me. She is the love of my life; we have been married 25 years. James

For Dot her husband's health deteriorated causing him to give up work and them to move into sheltered housing as a result. This rapid decline in health,

change in circumstance and environment she believed contributed to her husband drinking heavily.

I met my husband and we married and had two boys. My husband has died though. We had our own house and his health deteriorated and we moved in here together. He couldn't get out and that's when he started drinking. Dot

For Brian the consumption of alcohol was a culturally linked one as he met and married an Italian whom he had met in the war.

I met my wife in Italy when I was there, she worked as a translator for officers you know; she was Italian. We would have one or two glasses at the most at lunch and dinner. Brian

For some of the interviewees their marriages were not successful and they ended in divorce.

I was 19 when I first married. When I was 23 that was when I got my first divorce. I've been married four or five times, I always picked the wrong ones. Anne

Anne was interesting in her fairly flippant attitude to marriage as she herself did not have a stable family upbringing as she was raised within the care system. Peggy's first marriage ended in divorce; and although she went on to marry a second time, the first marriage clearly left emotional scars that were visible when talking to her about it. For Jackie those emotional scars were ever present, as although she was still married she was estranged from her

husband, due to his health (he had Alzheimer's), being a victim of domestic violence and her own alcohol dependency as a result.

I'm still married, my husband is in nursing care, he has Alzheimer's. The marriage was very, very good at the beginning but rocky towards the end. Our marriage was over for a long time but we had separate lives. I think if he hadn't been ill we would have split up. I don't visit him my son does. There is a lot of history. Jackie

For Albert there was a sense of sadness around the fact he never married despite being with his partner for 14 years until she died.

I never married, I had a partner for 14 years but she passed away at 49. She had been married and divorced and didn't have any children. I asked her several times to marry me but she just said she'd been married once before and didn't want to do it again. Albert

5.4.4.3 The addition of children

For some of the interviewees, the adult relationships they had formed naturally progressed to the birth of children but for James the children from his first marriage, where he drank heavily, became a contributing factor to alcohol abuse.

They say I wasn't a father to them, they didn't see me. I paid the money [maintenance] but there wasn't anything there. I used to see them at the weekend and the first two years I

thought she was coming back and it came to a point where it wasn't doing them any good and I gave them the choice and they just cut it off. I regret not seeing my kids but I would be a rotten dad. They know where I live. I'm comfortable with it James.

5.4.5 Work Influence

The transition from work to retirement is often given as a reason for increased alcohol consumption in older people; however, within the participants it was not a topic area that appeared from the data. There were three interviewees who experienced the loss of employment through redundancy when they were 50 years old but none secured work again. Kenneth described how he had worked with the same employer for 21 years before being made redundant. He stated that he “just didn't bother” trying to find another job. For Albert he took early retirement and was in the best financial circumstance of his life but with a reduced social circle with whom to enjoy it. With both these interviewees there was a quiet contentment in finishing work and making a choice not to seek further employment. For Harry despite him experiencing depression after being made redundant at 57 he did not use alcohol to cope.

From the age of 57 I didn't work again, it was a difficult time. I felt low and depressed after a while because I was looking at people going out to work and I was sitting there not able to. I just thought I'd tried my best but alcohol didn't play any part in that. Harry

The experience for this interviewee being without work is the opposite of his earlier life when returning home from war.

Everybody who came back with me [from war] went back to their job that they had come from because there was plenty of work in the 50's. Very few people were out of work in the 50's. We were building the country up after the war, there was lots to do. Harry

For some of the interviewees the nature of their work made it easier for them to drink. Elsie did not drink but the fact that she and her husband worked in a pub opened up the opportunity for her husband to drink “a fair bit now I come to think about it”. For others such as Fred they were involved in social clubs; in this case the secretary and it was an accepted part of the social club scene. James had two experiences of work-based culture involving alcohol. He explained his experience of being in the merchant navy.

It was horrendous, it was a shock. I wasn't a shrinking violet but I never expected all the goings on. You know the queens and that were out in the open; that was a shock on ship. I drank heavily. James

James was not the only interviewee to mention heavy drinking on board ship both Brian and Percy had this experience.

I used to drink too much sometimes on-board ship, they used to automatically think you drank whiskey and you couldn't refuse. The Russians during the Communist times used to come on board and the first thing they would do is just a small

bottle of vodka and everyone used to drink it. I didn't like it, terrible stuff and the bottle had to be drunk before any business was done. Brian

Although Brian went on to only drink culturally in Italy stating that he could not drink much, Percy went on to become an alcoholic.

I would definitely say that by the time I came off the ships I was an alcoholic. I drank heavily every day; I don't know how I survived. I really did have a problem there and then. Percy

For James he moved from merchant navy to working from a brewery where there was an expectation to drink at each delivery.

I got a job in the brewery and I stayed for about 14 years. I was on deliveries. You could drink and drive and wherever you went they gave you a drink or two. You went to all the pubs. I was drinking heavily. James

For Percy once he came off the ships he secured a job working in the shipyards but continued to drink.

I used to drag myself in. I've been in some of the worst states in my life and still gone to work. It was the zen of the bottomless pit all in one really. I was just mainly working to drink you know and er that was it. Percy

For Dot it was an accident at work that facilitated her to witness the level of her husband's drinking.

My husband was a roofer and he was more on the pavement than he was on the roof. He couldn't get out and that's when he started drinking. I think because of his job when they were rained off they would go for a pint, so it was like a social thing and then they would have a drink before they come home and he would have a good drink. But when he wasn't able to work he would drink in the afternoon and then he would carry on, he wasn't what you would call an alcoholic but he had a problem. He couldn't not have a drink. Dot

For Jackie her isolation at work mirrored that of her marriage. Her husband had set up a shop to run together but removed himself from the day to day running of the business.

My husband wanted to be self-employed and I just tappy lapped [went along with] behind him. We bought a shop and that was the beginning of the end. It ended up that he did very little apart from going to the cash and carry and I ended up in the shop. Once it was closed at 10pm I had the books to do and sorting it out. It started as a drink to feel better, then a couple of nights later I'd have two never entering my head that I was taking away from the profit because I was drinking from the shop. Jackie

This interviewee did end up an alcoholic, with easy access to alcohol from the shop stocks. The decision to drink to hazardous levels was made easier by her not having to leave the premises, she could carry on working and drink from the shelves.

5.5 Discussion

Depression is the most common mental health problem experienced in later life and yet despite the clinical symptoms of depression being similar across the lifespan this age group receive less help than those under 65 years of age, depression in later life has become hidden (Lee et al, 2007). In later life there is a greater risk of major life events such as loss of employment, bereavement, and changes in social environment, isolation, loneliness and changes in health status (Koster et al, 2006). The majority of the research population talked about mental health as part of their life experience, as something they went through rather than the perception of being unwell. It was talked about as a symptom of something else in their lives.

Chapter 6 Case studies

As this research thesis has progressed the researcher found that as a review of the interview transcripts of the lives these 16 older people was completed, one question felt unanswered. What were the factors that determined whether a person drank alcohol? This became increasingly interesting in circumstances where two or more people had a similar life experience but only one of them drank and the other did not. Admittedly at times it seemed it was a question that was beyond the capabilities of me and this Doctoral study. However, the question became slightly consuming and it was only through the discussion writing process that a degree of clarity. It became clear to me that the stories that the participants were telling gave substance to themes that had emerged from the data. The story is often termed as 'the account that is told' (Frank, 2000). Generalisability in this circumstance is not the aim, more the personal narrative, from being thought through to being spoken, is a personal interpretation of the experience lived. The narrative is the part of the story that becomes available for the researcher to analyse and by doing so to expose the hidden meaning in the person's narrative (Riley & Hawe, 2005). The narrative form is the way an individual makes sense of an experience, especially when trauma or difficult life transitions have taken place. This is true of this research group and by detailing some of the background stories the understanding of the narratives comes through. The analysis of the story helps the researcher answer the research question (Frank, 2000). The verbal data given via the life stories contributed to the answering of the research question. The detailing of case studies contributes to the validation the data, working towards the prevention of the dilution of the of the personal experience by

analysis. I used framework analysis to prevent distortion of the data while making sense of it. From here the case studies encouraged consideration of how the participants made sense of their worlds.

The storyteller, the participant, has been influenced over their lifetime by many things, culture, knowledge, social construct, family, as well as who is listening (Bruner, 1984). It was perceived that from the participants perspective the listener in this case was the researcher, a white, educated female, a nurse, with some authority. Through the use of narrative enquiry and case studies the teller is able to establish a position of control and power. The storyteller is able to control what they what to share, how they wish to tell their story and when they wish to remain silent. They can place emphasis on any part of the story that holds value for them, this in turn could guide my interpretation of that data. All people have an internal voice which shapes how to act and what to say, often presenting information as rehearsed stories. However, once these rehearsed, descriptive accounts develop, they become explanatory stories with elements of justification of actions and beliefs. If there is shift to comfortable conversation there can also be an emotional reliving of the story leading to the research situation being forgotten and the story becoming the primary focus (Denzin, 1989). The guided request for an individual to tell their story, rather than answer a set of prescribed questions, relinquishes the power from the researcher to the individual. This shift in power enables participants to give more honest and open accounts.

It is my view that we all have a life course to be travelled with challenges along the way. Over that life course there are transition points; which as discussed

in Chapter 7 are crucial for development, progression and reaching individual potential. The specifics of transition stages are not discussed in detail here but are very well documented in Chapter 7. Narratives are useful for studying transformations and the transitions in people's lives. The consideration of epiphanies, the significant moments in the person's life, have enriched the accounts given via the life stories and have contextualised the stories (Usherwood & Hermansson, 2008). The presentation of case studies removes the feeling of the data being cut and pasted themes, producing broad categories and by default a broad understanding. Case studies ensure that the data is true to the original source as possible and demonstrate the person's own view of those transition points.

6.1 Interviewee case study summaries

Each interviewee was initially assigned an individual ID number which related to the AUDIT survey completed and returned as well as their interview this allowed the survey and interviews to be matched. However, as the stories were reread the ID number felt very impersonal, especially when the content of some of the stories was so emotional and therefore the decision was taken to use pseudonyms; thereby giving a human element rather than a number. The interviewee summaries include the ID number and the pseudonyms, the age at the time of interview, the age category they fell into for the research analysis (<70, 71-80 and 81 and over), the level of risk determined by their AUDIT score and a brief overview of the interviewee's life. This information can be seen in table 20 in a table for ease of reference.

Brian, ID2 Male aged 92 (81 and over) Medium risk drinker

Brian grew up with his mum and dad and one sister. Dad worked. He grew up with the experience of post war depression and rationing. He served in the Normandy landings of the 2nd world war aged 19. Despite never handling guns or weapons previously he was trained to do emergency repairs to weapons and cleared the guns that jammed while on the Normandy landings.

He met his wife while serving abroad but did not want to marry in case he did not make it back. He married his wife after the war, returning to one of the countries he had fought in as she was from another country. The couple adopted his wife's niece as her parents did not want her. This was the only child they had. They returned to the UK for a short time before settling in his wife's country of origin. He returned to the UK aged 80 once his wife had died after being out of the country for 35 years. He only had his sister as a contact in the UK.

Mary, ID13 female, aged 76 (71-80) low risk drinker

Mary grew up with mum and dad and had six brothers and one sister. She never married and had one child from a short-term relationship. Mary struggled with her mental health after the birth of her child and ended up on medication. Gained confidence in her later years to go out on her own to meet people, she has a good social network.

Table 20 *Participant characteristics*

Pseudonym	Identification number	Sex	Actual age	Age group	Level of drinking risk
Brian	ID2	Male	92	81 and over	Medium
Mary	ID13	Female	76	71-80	Low
Kenneth	ID24	Male	79	81 and over	Medium
Albert	ID28	Male	86	81 and over	Low
Peggy	ID30	Female	84	81 and over	Low
Jean	ID36	Female	78	81 and over	Low
George	ID37	Male	77	81 and over	Low
Percy	ID40	Male	61	<70	Low
Elsie	ID42	Female	63	<70	Low
James	ID48	Male	66	71-80	High
Anne	ID50	Female	72	71-80	Low
Harry	ID52	Male	75	71-80	Medium
Dot	ID59	Female	72	71-80	Low
Jackie	ID61	Female	70	71-80	Low
Fred	ID62	Male	70	71-80	Medium
Bob	ID63	Male	73	71-80	Low

Kenneth, ID24 male aged 79 (81 and over) medium risk drinker

Kenneth was brought up during the war outside the family as an informal arrangement as his mum died. He had a half-sister by the same father. There was the experience of rationing while growing up. Kenneth never married. He was made redundant in his early 50's and did not work again. He did not serve

in the forces so had little in common with the men living around him. He was isolated and had little contact with others.

Albert, ID28 male aged 86 (81 and over) low risk drinker

Albert grew up with his mum, brother and half-brother. They had the same mum but different dads. Both his brother and his dad died when he was a child. His mother did not remarry. He experienced serving in the war and was injured and returned home before the war ended. On his return home, he had the experience of rationing. He never married although he was in a relationship for a number of years until his partner died after a short illness at a fairly young age. Following this bereavement, he had a mental health breakdown. In his later life he found that he had lost most of his friends but despite struggling financially all through his life he was in a situation where he had money to spend but no one to do things with. He had no children and was isolated relying on health and social care for social contact.

Peggy, ID30 female, aged 84 (81 and over) low risk drinker

Peggy grew up with her mum and dad, one brother and three sisters. She was married twice. Her first husband could not have children but did not make her aware until after the wedding, he actually blamed her for not being able to conceive knowing all along that he was unable to father children. She filed for divorce which took five years to finalise. Peggy met and married her second husband and they had three children together. The third child contracted Reyes syndrome and ended up with permanent brain damage. This affected the marriage for the rest of its duration until her husband died. She had a

mental health breakdown resulting in inpatient treatment as a result of looking after her disabled child for 18 years. Her husband drank nearly every night. She was very self-sufficient and focussed on her children and grandchildren. The death of her husband was sudden following a stroke at home, where she found him in a state of collapse.

Jean, ID36 female aged 78 (81 and over) low risk drinker

Jean grew up with mum, dad and seven brothers and three sisters. She joined the war effort on the switch board. Jean married and had six children. The marriage was described as very happy until her husband died after a period of ill health. She has a good social network but still grieves the loss of her husband.

George, ID37 male aged 77 (81 and over) low risk drinker

George grew up with mum and dad, three sisters and one brother. His dad was in the army from age 15 and the whole family were born abroad. His father returned from war with a drinking problem and as a result split from the mum and the children didn't have much contact after that. They lost their home due to financial struggles resulting from the father leaving and as a consequence the mum worked a few jobs to support the family. He has always been religious since he was a child. He married and had two children a girl and a boy but his wife rejected the girl, so they divorced and he got custody of his daughter while his wife kept their son. His wife never had contact with their daughter again. He returned to the UK to continue his religious studies. He married for a second time but divorced due to his wife's poor mental health. He then married for a

third time and although they are separated and do not live together they still have a relationship where he supports her a few times a week. He is still married to his third wife. He feels that faith gave him the strength to take a deep breath and carry on, he does not drink because of the experiences he had with his own father.

Percy, ID40 male aged 61 (<70) low risk recovering alcoholic

Percy grew up with mum and dad and one brother. His father was a prisoner of war which affected their relationship; he described it as functional and not very affectionate. He trained in a trade and had more of a father like relationship with his mentor which continued to the current day. The death of his parents had an impact on him. He married twice and had two children but has no relationship with them due to his own alcohol misuse. He felt all his life that he had little in common with those around him. He travelled widely as part of his job but never really settled. He was an alcoholic who at times was close to death; he stated he felt predisposed to alcohol misuse.

Elsie, ID42 female aged 63 (<70) low risk drinker

Elsie grew up with her Mum and dad and four brothers. She was married but her husband drank and as a result was abusive. The marriage ended and this felt like a death to her, her mum also died around this time and she ended up on medication and drank alcohol to cope. This lasted for a year. She started to work part time and then full time, she did marry again but this marriage also ended in divorce due to infidelity. This time she relied on family and friends for support. Worked in a job she enjoyed and had a good social life.

James, ID48 male aged 66 (71-80) high risk drinker

James grew up with mum and dad, one brother and two sisters, one sister died when she was young. Mum and dad both drank and it was like a big social occasion with singing around the piano and lots of people gathered together. He was only born because of the death of his sibling and this had a profound effect on him throughout his life. He still visits the graveside of the sibling who died. He was independent from an early age and has exposure to sex workers and drinking from around the age of six. He worked away at sea and was exposed to new social experiences such as openly gay men and heavy drinking. He joined the army but could not manage the instruction and so worked for a brewery. He married and had two children but his drinking caused problems in the relationship and he got divorced. He has no contact with his children which he states he is ok with as he would be a terrible father. He had real problems dealing with the grief following the death of both his parents which happened close together and he drank heavily to cope with this. He states he has depression and drank to self-medicate. He is well travelled through work and this was at times a contributing factor to his drinking reaching the levels to where he was unwell. His sister died from alcohol misuse. He felt that alcohol use was only ever a problem when he was in a relationship because he became answerable for his actions. He married a second time while studying at university as a mature student. He calls this lady his life saver. Drinking in this relationship became a social activity rather than an isolated one. His second wife also has two children who she is estranged from. Drinking alcohol is his default coping mechanism, he would binge drink when not coping. He states that drinking has always been his partner, like his shadow.

Anne, ID50 female aged 72 (71-80) low risk drinker

Anne's mum died and she did not know her father. She was taken into care from age three until 15. She had three failed foster placements during this time. She had contact with her dad and a sister and a brother when she was 10. Her dad died shortly after and she had limited contact with her sister after this. She states she led a sheltered life from being in care and knew nothing of the world so it was a shock to be in work at 15 out of the area. She married at 19 and was divorced with two children by 23. She was raped and this resulted in a pregnancy but her eldest daughter was also raped by the same man; he did receive a custodial sentence. She decided to keep the child from the sexual assault but lost her other two children as a result. She married for a second time and became pregnant but had a termination at her husband's insistence. She then had an affair as a consequence of this and later divorced. She married for a third time and divorced again after seven years. She married for a fourth time but her husband died following an illness. Her fifth marriage only lasted two years as her husband died. She describes this marriage as her happiest as there was no sexual relationship. Her daughter has seven children all of whom are in care due to her daughters drinking and drug use. She would like to marry again as she feels lonely.

Harry, ID52 male aged 75 (71-80) medium risk drinker

Harry grew up with his mum and dad and two sisters. He completed his national service, married and had two children. His wife was chronically unwell and he was her carer. This was a difficult relationship as his wife struggled with the fact he cared for her. He was made redundant in his 50's and really

struggled with this as he could not get work. He was not in paid work again for the rest of his working years. He volunteered for the rest of his working life. He and his wife separated due to the strains of the carer role and he viewed this as a temporary arrangement. His wife died suddenly while they were separated and he held a huge amount of guilt around this. He had problems with his mental health and was hospitalised. He still has treatment for depression. He now feels very isolated but attended church. He stated he did not see his daughters very much even though one of them called in each day to drop off a newspaper for him. He was socially included but lonely.

Dot, ID59 female aged 72 (71-80) low risk drinker

Dot grew up her mum and dad and one brother. Her dad died when she was 15 years old from suicide. He hung himself in the wash house and she found him. She later had a career in nursing. She married and had two children. Her husband drank heavily but due to ill health had to stop work and his drinking increased. This was the first time she saw the extent of his drinking as previously it had been masked by a drink with his friends after work. Her husband died shortly after they had moved into sheltered housing. She was actively involved in the sheltered housing scheme, had friends there and liked the security it gave. She had her own health issues but had the church as constant support. She would take part in activities with her friends in the communal lounge and this often involved a few drinks.

Jackie, ID61 female aged 70 (71-80) low risk drinker (recovering alcoholic)

Jackie grew up with mum and dad and one sister. Her dad was in the army but it was her mum who was strict. When she was aged four she fell down a flight of stairs and broke her pelvis, arms and legs and was in plaster for two years. She was home schooled. She did not attend school until she was six years old but was then hospitalised for a second time aged 10. As a result, she missed taking the 11+ exam and had to then leave school at age 14. Jackie felt she had missed an opportunity as she loved to learn. She married and had one son, she had hoped for more children but this was something her husband was not keen on. The marriage was not good from the birth of her son and she stated she felt like a single parent. Her husband drank heavily and was abusive both emotionally and physically. She stayed with her husband until he had a massive stroke and went into nursing care, they are still married but she does not have any relationship or contact with him. She stated that she was robbed of her personality by her husband. The relationship contributed to her drinking alcohol to block out the problems. She felt she was trapped in a life that she did not want. She was in her early thirties and going through an early menopause. When the drinking was discovered she was taken to alcoholics anonymous by a family member. She had a nervous breakdown when she had to face all her problems without alcohol, was hospitalised and attempted suicide more than once. She blamed her husband for her drinking. She eventually recovered and got a job and then went to university and trained to be a social worker. She stated that the person I am now would have left but I always had low self-esteem.

Fred, ID62 male aged 70 (71-80) medium risk drinker

Fred grew up with his mum and dad and one brother. When his parents divorced he went to live with his gran. He did not mention any kind of relationship with his parents. He married and had two children. He held down a job with the same employer all his life and was the secretary in the local social club. He described his life as straight forward and uncomplicated.

Bob, ID63 male aged 73 (71-80) low risk drinker.

Bob grew up with his mum and dad and three sisters. He lost his business, divorced his wife and had deterioration in his health all within a short space of time.

6.2 Case study discussion

Public Health England aims to improve public health through strengthening local action, supporting self-esteem and behavioural change, promoting healthy choices and changing the environment to support healthier lives (Department of Health, 2013). Behavioural theories such as the Theory of Planned Behaviour (Ajzen, 1991) and the Health Belief Model (Rosenstock, 1974) recognise factors such as threat of a disease, but they do not account for the role of emotion, personality traits or cultural influences (Werner, 2004). These individual characteristics influence personal perceptions on whether the person has reason to change (Weinstein, 1987). Personal risk or susceptibility is believed to be one of the more powerful perceptions in prompting people to adopt healthier behaviours (Rosenstock 1974). However, a perception of increased susceptibility does not always lead to behaviour change as described in the Health Belief Model

(Rosenstock, 1966). The construct of perception is modified by other variables, such as education, culture and past experiences. This can be seen in the case studies (James, ID48) where exposure to alcohol as a child normalised the use of alcohol in later life and reduced the perceived risks. Alcohol in his context is used as a legitimate behaviour that otherwise may have been perceived as unacceptable or too risky (Skinner & Smith et al, 2008). Most adults in the UK consume alcohol and its use both influences and is influenced by social and cultural norms (Health and Social Care Information Centre, 2015). Perceptions and beliefs about the risks associated with alcohol consumption are shaped through public and policy debates. This may lead people to regard their own drinking practices as unremarkable (Valentine et al, 2007). This experience may also have diminished the person's perception of the seriousness of the consumption of alcohol over the recommended limits, which is a further construct of the Health Belief Model.

The case studies have encouraged the common experiences of the interviewees to be highlighted outside of their individual experiences. This has enabled the bringing of common areas for discussion to the fore. It has been highlighted from the case studies that if an individual goes through any of their early years, childhood and adolescent transitions without disruption (notwithstanding scenarios such as teenage angst, some experimental behaviour and boundary testing) they are likely to have developed a sense of internal locus of control. This individual is likely to seek out the knowledge and information they think they require in order to deal with the presenting issue and continue the life transition smoothly. They are generally more motivated to self-problem solve. An individual with a strong internal control would seek

support from friends, family or religion as there is a belief that they themselves can influence and alter their own lives by drawing on support and, therefore, the experiences of others. The focus on external support only serves to reinforce the strength of the ability to self-control. The more a situation is considered to be within the control of the individual, the more it is considered to be low risk (Weinstein, 1987). When an individual has the experience of a disruption at a later transition point, it would appear to knock them off their core life course because of the self-belief they hold; developed from previous experience. When another disruption to transition is experienced later in life, they have enough trust in and experience of the belief of their ability to exercise self-efficacy and self-management and continue to employ similar recovery strategies such as friends, family, religion and asking for external help and support as required. This then means that they are less likely to use alcohol as a coping mechanism in the long term. The construct of perceived costs and benefits which is present in the Health Belief Model (Rosenstock, 1974) and the Theory of Planned Behaviour (Ajzen & Fishbein, 1980) focuses on the individual's opinion of the benefits and costs of a behaviour change in preventing a disease, or in the case of this research, alcohol misuse.

If an individual has had a disruption to transition at the early years, childhood or early adolescent development stage then they are likely to have had less opportunity to develop self-efficacy and self-esteem. This person is less likely to believe that they can alter and influence their life course rather believing it is set in fate and luck or a predetermined path. This person is not likely to be motivated to work to change or improve their life course and will be more inclined to rely on alcohol as an external control in their life. It has been

suggested that an individual's perceived ability to carry out a health strategy successfully may greatly influence their decision and ability to enact and sustain a changed behaviour. Previous research has shown that as individuals often rationalise risk taking behaviour using a range of socially constructed criteria, this could explain the apparent mismatch between objective risk and personal risk (Abrams & Abraham *et al.*, 1990).

Of course, the trajectories for both internal and external locus of control are not fixed; they are fluid, dependant on the situation and experience and whether any additional life learning has been achieved (for example, therapy or support groups). For example, a person's self-worth within an abusive marriage can be very low and coupled with an externally focussed locus of control the person may not see a way to leave. There may be the view that they chose the partner and the relationship; that they in some way contribute to the partner's abuse, that they might provoke the behaviour and cannot change the person their partner is. In this type of scenario, the person may use alcohol as the control in the situation. However, it could be that a person with an external locus of control with the use of an external intervention (such as alcoholics anonymous) that self-worth and self-esteem can be worked upon altering the confidence levels and a shift from an external locus of control to a more internally focused locus of control thus opening up alternative viewpoints of their current situation. It might not be a complete change in that some areas of their life will continue to have an externally focussed locus of control but in terms of their alcohol use and the relationship they have the skills and knowledge to change these circumstances and their response to it. The interesting concept in relation to this thesis is whether the person has an

internal or external locus of control could determine not only the likelihood to use alcohol but it could also have an impact on the support offered and the type and manner in which any health-related information could be presented to an individual.

Interviewee Elsie was brought up in a family with a mum and a dad. She was very timid and shy and when she left school at 15 to start work she experienced some bullying from her colleagues. She described herself as having low self-confidence. She was protected by her family and this extended into her working life where she went to work in a shop that was managed by her older brother. Elsie married at 19 years of age but her husband was physically abusive. She left the marriage which she described as akin to a death as she had married for life. Elsie ended up on medication and drinking alcohol to cope.

At the same time as her marriage ending she also experienced the death of her mother and so to some extent experienced cumulative grief. Elsie stated that she felt very alone during this time even though there were people around her and that she had lost all confidence. Elsie drank heavily for 12 months and then stopped. She managed to get a job that she enjoyed and her job, her friends and her family became her support. This interviewee is an example of where the individual had low self-esteem and low self-confidence so during a crisis she was unable to state what she needed to those around her and therefore alcohol seemed to be the only answer. Once she received additional medical input and was able to reach out to friends the drinking stopped. In this case the past experience is used to determine the future vulnerability, there is

the initial intention to change behaviour with additional variables such as emotions influencing behaviour (Werner,2004; Ajzen,1991).

Anne was brought up in care from the age of three. This ordinarily would be classed as a major disruption but for this interviewee she did not know any different and thought of the care placement as home. As a result of being in care she was very independent and self-sufficient. Anne did not have anyone to rely on apart from herself. She also left school at age 15 and went away to work in a factory for two years.

Anne struggled with personal relationships in her life including her foster placements (three failed placements), her husbands (five marriages) and her own children. It was as if Anne did not have a model of family relationships or personal relationships on which to base her adult life. She married when she was 19 and was divorced with two children by the age of 23. When she and her first husband separated she went out with a friend and this resulted in a serious sexual assault and the conception of a child as consequence. Anne made the decision to keep the child which then led to her losing custody of her other two children. This traumatic event was discussed in very matter of fact terms with the focus being on the child and the search for her next husband. The resilience that she had developed in her early years while in care carried her through the situation without the requirement for alcohol as a support or the need for medical intervention. In these two cases it was the skills that were developed in their early years which then determined their coping strategies in challenging times in later life.

Dot was brought up in a close family who did not have much money. She experienced the death of her father at age 15. He committed suicide in the family wash house and Dot discovered his body. Even though she left school at a young age without any qualifications she went on to train to be a nurse and had a successful career in nursing. She married and had two children. Her husband drank heavily and this increased when he was injured and unable to work again.

This interviewee stated that she had always been involved in the church throughout her life and this not only helped her deal with the death of her father but also her husband's drinking. She claimed to have gained strength from the church, using the power of prayer to help her through any difficult times. Dot stated that the church, religion and her social network allow her to get on with things without the need for alcohol. This individual could have experienced a severe disruption to her teenage developmental years from the death of her father but it would seem that the close family and the links to the church have helped her to establish strong self-control.

George had been involved with the church and religion all of his life. He worked as a missionary for some time overseas. He did experience disruption relating to his family when he was aged nine as his father returned from the war alcohol dependant. This resulted in the divorce of his parents. His mother struggled to provide for her five children and they lost their home and ended up living in a shelter. The family were however a very close unit and a good support to each other. George had a number of difficult marriages with one resulting in a custody dispute over the children. His wife did not want anything to do with

their daughter and so he ended up with the full custody of his daughter while his wife had their son. As George had experience of alcohol misuse, and the consequences of that action by his father this could have led to a heightened perception of susceptibility because of his past experience (Rosenstock, 1974).

There were two out of three marriages where the wife had serious mental health difficulties and in one marriage where this actually caused George to become homeless. George stated that he did not drink partly due to the experience of his father's alcohol misuse and secondly due to his faith and his family, that these elements in his life gave him strength and the ability to get on with things without using alcohol to cope. George presented as someone who had a strong internal locus of control developed from the strong family based child development.

Peggy had a good family upbringing but describes herself as a loner and as being happy in her own company. She did not experience any disruption to her development as a child. She married aged 19 and hoped to have a family of her own but discovered once married that her husband could not have children. This was something he had not disclosed to her prior to the wedding. They divorced after five years of marriage. Peggy married for a second time and had three children. When her third child was about 10 months old she had a seizure that resulted in permanent brain damage. This was a highly traumatic event in Peggy's life.

As a result of this incident Peggy found her husband to detach from her emotionally and drink in the pub on most evenings. Her husband felt very strongly that their daughter should be cared for in an institution rather than being at home with the family. This was at a time when there was much stigma around those with a disability. Peggy stated that from this point on she felt like a single parent and struggled with the care of her daughter. When the daughter was 11 years old Peggy had a hospital admission as her mental health had deteriorated. She was treated with electroconvulsive therapy for depression. Peggy never drank alcohol; she stated that as long as she had her children, her grandchildren and her great grandchildren they were her focus. Peggy had a group of friends but these were the wives of her husband's friends rather than friends in her own right. Peggy presented as a quietly strong person who was very self-sufficient, she knew when she needed to ask for help both for herself and her daughter and this is likely to have prevented the requirement for the use of alcohol.

Jackie stated that although she did not currently drink, she had previously misused alcohol to the point of addiction. Jackie was raised in a close-knit family where she was the only child. This was something she did not like and wished she had a sibling. At the age of four she fell down a flight of stairs and broke her arms, legs and pelvis, resulting in her being in plaster for over two years. She did not attend school for many years due to this accident, she had some home schooling but it was not the same as attending school. When she did finally return to school she contracted rheumatic fever and had a prolonged hospital admission once more.

Due to her ill health when she did attend school she was always made to sit at the front of the class when all she wanted was to sit at the back. As she missed so much of her early schooling she was not able to sit the 11+ exam and had a strong feeling that she had missed an opportunity. She felt she was clever but had not had the chance to learn to her potential. This is something she would draw upon at a later stage in her life. Jackie stated that she always had low self-esteem and was happier in the background. Jackie did marry and have one son; however, the relationship was both physically and emotionally abusive. Her husband showed little interest in her or her son once he was born. She described her husband as domineering and that on the occasions that he was physically abusive he blamed her. She stayed with him through this as she could not see a way out. Jackie stated that she felt robbed of her personality and trapped in a life she did not want. She started to drink alcohol to cope and this quickly escalated to a situation where she was drinking every day. It was three years before her husband was aware.

A family member took her to Alcoholics Anonymous and the GP where it was discovered that she had started an early menopause and had depression. Jackie was admitted to hospital for her mental health and had several attempts at ending her life. After a period of hospital treatment and being placed on medication Jackie felt she has support around her from people who were not judging her. With the ongoing support for her mental health she decided to try and find work, her husband told her that no one would employ her but she found work as a care assistant. Jackie states that she could feel during this period that her husband had lost his control over her.

The support she had received assisted her in developing her self-esteem and self-worth. Jackie took the opportunity to learn that she missed out on as child and attended university and trained to be a social worker. This gave her a sense of pride, achievement, her own income and she felt she had found her place in the world. Her husband had a severe stroke and ended up in care. Although she is still married to him she has no contact with him. Jackie has not had an alcoholic drink in 30 years. Jackie is a good example of where external intervention can facilitate the development of skills to enable an earlier life course disruption not to affect the forward trajectory.

Percy mirrored the feelings expressed by Jackie of not quite having a place in the world. Percy stated that he felt that he did not fit in with his family; the relationship with his father was very unemotional. Percy was given the opportunity to travel, working for an international shipping company, and stated that these were very exciting times and removed him from his mundane life as a plumbing apprentice.

Percy stated that he had a problem with alcohol right there and then once on board the ships. This misuse of alcohol continued when he returned off the ships to an even greater degree as his sense of not quite fitting in was highlighted to him more upon his return. He had experienced so much of the world and felt that those he now worked with on the shipyards had lived very small lives. He stated at this point he was working to drink. Percy stated that he felt the travel had changed him. He went on to marry and have two children who he had no relationship with as a consequence of his drinking. Percy did not have any friends who were not drinkers apart from his work mentor from

his teenage years. He described this man as a father figure. His drinking reached a point where his health was at risk and it was at this point he decided to stop drinking. He attended Alcohol Anonymous following the death of his parents and this seemed to be the catalyst to him ending his search for his place to belong.

Percy states that he has only known disappointment in his life despite experiencing a successful working life. He is very self-critical and does not socialise preferring to keep himself to himself. Percy stated that he believes that no matter the path he had taken in his life he was predisposed to becoming an alcoholic.

James had a very happy childhood, but he stated that he struggled to find his place in the world. He knew that his parents had only decided to have him as his older brother had died. This was something that weighed heavily on his shoulders despite a very close-knit family unit. He still visited his brother's grave into his adult years, placing his own existence on the death of his brother. He embarked on a career at sea joining the merchant navy. He states that he drank heavily on board the ship and knew very quickly that he had a problem with alcohol. When he left the merchant navy he ended up securing work for a brewery where alcohol was offered on a daily basis.

James married and had two children but due to his alcohol misuse does not have contact with his children. He stated that his alcohol use was only ever an issue when he was in a relationship because he then became accountable for his actions. His parents who he was very close to both died within quick

succession of each other and this caused an escalation in his drinking as he tried to block out the emotional pain he was experiencing. He was also diagnosed with depression at this point. Despite being offered rehabilitation for his alcohol misuse he only managed to stay for a few hours before discharging himself from the unit. He never acknowledged his drinking as problem apart from when he was in a relationship demonstrating his external fixation on the level of control he had. James married for a second time but in this relationship, he states that for the first time he was not drinking on his own, he and his wife were social together. James fully admitted that drinking is his default coping mechanism; that he drinks to mask how he is feeling. He describes drinking as his partner, like his shadow, alcohol does not ask for an explanation.

Although James seemed to have a good childhood he did disclose that he had a lot of freedom as a child, making his way independently around central London at the age of six. During this time, he was exposed to prostitution and alcohol use. This lack of parental guidance coupled with his sense of guilt over the death of his brother could have contributed to his sense of not fitting in and trying to find and test boundaries. This interviewee had not stopped drinking to harmful levels on occasion but his drinking had reduced. He was very aware of his own drinking behaviours and the triggers for doing so. He had an externally focussed locus of control not only with his alcohol use but in the security, he attributed to his relationship with his second wife describing her as his life saver.

Chapter 6 Summary

This chapter has presented the interviewees biographical narratives as case studies. These have been discussed in relation to the relevance of behavioural change theories and the limitations of these theories to help understand older people's drinking behaviours. The perceived risk in terms of drinking behaviours and the acknowledgement of the need to change were considered in the context of the case studies presented.

Chapter 7 Discussion of the qualitative study

7.1 Research aim

The aim of this research was to establish the factors determining decisions to drink in later life. From the interview data and the framework analysis there were five topic areas that presented as factors determining the 'why' of older people's drinking. These were mental health, domestic violence, social contact, family and work.

7.2 Findings summary

7.2.1 Mental health

Some of the participants interviewed had a diagnosed mental health condition for which they had or were receiving treatment for. The remaining participants although not diagnosed formally still made reference to states of stress and or anxiety. The participants described their poor mental health as a symptom of something else in their lives rather than an illness; it was in general terms a response to an event or episode in their lives. Poor mental health presented as both a protective and a contributory factor for alcohol consumption. It was protective in those who accessed support from medical professionals and who took the use of medication and advice given with seriousness preventing the consumption of alcohol while on medication. For others, they drank to self-medicate initially only to realise that troubles reoccurred and had to be dealt with a second time without alcohol.

7.2.2 Domestic violence

Of those interviewed, seven interviewees had experience of or exposure to domestic violence. For some alcohol was used to cope with the situation they found themselves in and for others their own drinking was itself a cause of domestic violence.

7.2.3 Social contact

The social contact experienced by the participants varied. It was highlighted that most of their friends had died and that social opportunities outside that with family were with new contacts and this was perceived by some as unsolicited friendship. For some of the participants the contact with family was their only social outlet while others chose to be alone declining offers of involvement. In all instances, there were occasions where alcohol was part of social contact but not a factor in the decision.

7.2.4 Family

The role of family was expressed with a degree of influence by all of the interviewees. Family did not necessarily present itself as a direct factor relating to alcohol consumption but the importance and influence of family through the life course presented itself as a factor in later life behaviour. The biographical narrative of the interviews allowed more of the life story of the interviewees to unfold often placing the current experiences into context. The social construct of family is complex and this does not simplify with age.

7.2.5 Work

The struggle of losing work and not being able to work due to poor health were presented as more challenging along with specific areas of employment that held strong traditions with drinking culture.

7.3 Links to literature

7.3.1 Older people's alcohol use

The Office of National Statistics predict that by 2031 there will be 27.2 million people aged 50 and over (ONS, 2008). Alcohol consumption and alcohol related deaths have increased among older age groups (Gilhooly, 2005). With an increase in life expectancy within the older population and an increase in its number it is likely that heavy drinking among older people will be widespread if current trends continue (Wilson et al, 2013). Substance use by older people is a public health concern (Wilson et al, 2013). Much of the current literature acknowledges that there is little qualitative research on older people and alcohol use and yet there is a continued dialogue around the reasons older drink including bereavement, retirement, loneliness and isolation, homelessness and depression (Holley-Moore & Beach, 2016). Older people are often wrongly treated as a homogenous group which belies the complexity of the lives older people live (Age UK, 2012). The life course older people have already travelled should by its very nature cause an increased complexity of the individual as the influences, impact and consequences of experience leaves its mark. The factors determining why older people drink are multifaceted and complex and are indicative of more than one isolated life

event. As with younger people the older person has personality traits and a history that drives and determines their current experience.

Although this research does not provide explicit answers to the question of factors determining decisions to drink it does provide some clarity on the broad headings referred to frequently in the current literature. Loneliness and isolation will be discussed to determine the place that the sheltered housing environment has in relation social isolation and alcohol consumption. Life transition and the importance of the life course will be considered against the backdrop of the biographical data collected. Retirement as one of the more commonly referenced life transitions will be discussed in the context of current literature and the interview data collected. Discussion around family and the overarching impact it can have will try to contextualise the importance of a good start in life. This research proffers the rare opportunity to consider a person's life from childhood to current day rather than a snap shot in time.

7.3.2 Isolation and loneliness

The findings from this research has highlighted some of the factors that contribute to the interviewees consuming alcohol. Some of the participants interviewed had a diagnosed mental health condition for which they had or were receiving treatment for. The remaining participants although not diagnosed formally still referred to states of stress and or anxiety. The participants described their poor mental health as a symptom of something else in their lives rather than an illness; it was in general terms a response to an event or episode in their lives. The social contact experienced by the

participants varied. It was highlighted that most of their friends had died and that social opportunities outside that with family were with new contacts and this was perceived by some as unsolicited friendship. For some of the participants the contact with family was their only social outlet while others chose to be alone declining offers of involvement. These findings although not directly referred to as loneliness and isolation by the interviewees does highlight that social contact and family relationships are important and can result in reduced mental health. It is therefore a natural progression for isolation and loneliness be discussed. Isolation and loneliness are often used as interchangeable terms but are actually distinct in their nature. Loneliness can be described as the gap a person feels between the social interactions a person has compared to the quantity and quality of the interactions they would like or expect (Cutler, 2012). Weiss (1973) hypothesised that there are two types of loneliness, social and emotional. The lack of a close emotional attachment to another person such as those who have recently divorced or have experienced bereavement can result in emotional loneliness. For Jackie (ID61) she drank following a bereavement coupled with the fact she was in an unhappy relationship which was akin to a second bereavement in her life. Social loneliness (isolation) results from a lack of social contact, a lack of network where there is no common interest between groups of friends (Weiss, 1973). Loneliness is distinct from isolation and is a reflection of the deficiencies in relationships held for example there are not enough of them or they do not offer what the person requires such as a level of intimacy (Russell et al, 1984). For Kenneth (ID24), he stated that he felt that he had little in common with those around him and declined offers of socialising. There is a belief that

different types of relationship meet the different interpersonal needs and that it is a biological response much the same as thirst and hunger to seek out meaningful social contact and belonging to social groups (Weiss, 1973; Goodman et al, 2015). People can have few social contacts and not feel lonely while others have more social contacts but still feel lonely and dissatisfied with their social circumstance (Goodman et al, 2015). For many people loneliness is a transitory experience and it is only if it becomes a persistent state that negative effects are felt (Age UK, 2012). Peggy (ID30) for example stated that she had always been a loner.

Demographic trends are placing increasing numbers of older people at risk of loneliness and social isolation, an established risk factor of morbidity and mortality (Goodman et al, 2015). Within this research there was mention of being the last man standing and a sense of being alone, although it was not explicitly referred to as being lonely. There were a couple of participants who stated they were lonely but qualified this with the fact that those they lived close to had little in common with each other. They filled the friendship void with other activities such as fitness, gardening or keeping in touch with friends who no longer lived nearby. They declined offers of social engagement preferring to stay alone rather than create new contacts.

Previous research has highlighted that 5-16% of over 65-year olds feel lonely most of the time (Goodman et al, 2015). Older people are often prepared to cope with loneliness as they expect at some point as they get older to lose friends and family and there is a steep rise in loneliness in the older old; 80 years and over (Age UK, 2012). People who have good social relationships

have a 50% decreased risk of mortality (Goodman et al, 2015). Loneliness has been linked to physical and mental illness including alcoholism (Russell et al, 1984). Lonely people are prone to depression and the lonelier a person is the more likely they are to experience increased depressive symptoms. There was a high level of diagnosed and self-reported mental illness, mainly depression and anxiety, within the research group. It could be suggested that this was due in part to loneliness. There was little mention of loneliness as a direct term but this could be due to the stigma associated with loneliness resulting in a reluctance to engage and disclose (Goodman et al, 2015). This might bring some clarity to those few individuals who stated they were lonely but chose to remain alone.

The social behaviour of those who are experiencing loneliness indicates a level of deficit in their social skills and abilities (Russell et al, 1984). Those who are lonely can be less attentive to what other people are feeling and what they might need. Interactions with others both positive and negative are perceived in an increasingly negative light, ultimately impacting on any relationships (Age UK, 2012). The lonely person can have a negative view of themselves and become unresponsive to others in social situation (Russell et al, 1984). Emotional loneliness can lead to feelings of anxiety and isolation even if it is self-imposed. Self-regulation becomes harder to manage, behaviours such as over eating, drinking and smoking can become uncontrolled without social contact to encourage healthy behaviours (Age UK, 2012). A lack of personal resilience could lead to loneliness but people need confidence to seek social contact (Goodman et al, 2015). The move into sheltered housing is cited as a trigger for loneliness when it would seem that the majority of the research

participants moved into this accommodation type to receive support and gain social networks (Cutler, 2012). It should not be assumed that because people live communally that they cannot be lonely especially if the people close by are not the type of character you would normally socialise with.

There is much work completed on how to reduce loneliness but little understanding on how to prevent it in the first place (Age UK, 2012). Loneliness is made up from internal and external forces and it is therefore hard to alleviate especially if there is the need for social contact and a meaningful relationship (Cutler, 2012). Those who are lonely tend to use health and social care services to a higher degree and are more likely to have an early admission to residential and nursing care (Cutler, 2012). Within the sheltered housing environment, the role of the warden has always been viewed as important in identifying and supporting the needs of residents. For some of the participants the warden was mentioned as the only regular consistent contact they had. It would appear that this role is perfectly positioned to work with those residents who are lonely and isolated but due to the recent Governmental austerity measures levied at local authorities there have been financial implications social care and the supporting people budget, the sheltered housing included in this research had involved the time that wardens spent in each scheme (Reeves et al, 2013). Historically each scheme had a full-time warden but the reductions in resource resulted in one warden covering two schemes. It would be prudent given the level of mental illness and the increasing older population that loneliness and isolation become part of the care business for sheltered housing providers. The campaign to end loneliness was established in 2011

and despite the Government support and engagement from charitable organisations, the translation to practice still requires some work.

7.3.3 Life Transition

Much of the current literature acknowledges that there is little qualitative research on older people and alcohol use and yet there is a continued dialogue around the reasons older drink including bereavement, retirement, loneliness and isolation, homelessness and depression (Holley-Moore & Beach, 2016). Transitional periods or events in a person's life are frequently mentioned within the literature as a trigger for alcohol use. Little explanation is given to these other than the understanding gleaned from the broad heading. This research aimed to determine factors in the decision to drink and to that end a deeper understanding was required. To grow old is a great privilege and it allows the retrospective vision on that life but it would seem that to achieve a content retrospective vision takes a lifetime of training and development (Erikson, 1978). Much of the focus on development is in the well documented childhood stages with the general view that no development occurs once adulthood has been reached. There is an acknowledgement by Freud that childhood development profoundly influenced the adult life but that any opportunity for fundamental change ceased at age 40 (Levinson, 1978), however with people starting families later in life and a change in retirement age this is now largely debunked. Erikson (1978) primarily devoted himself to the study of adult development believing that the last stages of life seem to have great significance (Erikson 1978; Levinson 1978). Life events are benchmarks of the human life cycle; they are milestones or transition points which give shape and

direction to a person's life (Sugarman, 1995). Transitions can be periods of both risk and opportunity, the risk that the individual will be unable to cope; the outcome being emotional scarring, the opportunity is for personal growth. Life events or transitions cannot be halted but the intention should be to enhance the individual's ability to grow and develop as a result of a life transition or event (Sugarman, 1995). The life cycle is not a simple continuous flow there are stages within it, each with its own character, the transition occurs as the person shifts from stage to stage or when there is a significant life event that causes a change (Levinson, 1978).

The methods used in this research established a picture of the person's life as a whole and how the various components were interrelated at certain points and how the current life pattern had emerged from the past. Life events can be handled with varying degrees of effectiveness. Individuals often need to draw on their own resources and the skills and attributes required to cope. An example of this is the struggle some people face to fill the spare time as a result of retirement; this can be a stressor for some people and potentially result in the consumption of alcohol. It is essentially the management of thoughts, feelings and behaviours of the person that determine the experience of the transition, if a person plans what they will do with that time and view the transition as a positive then they are less likely to feel stressed by it (Sugarman, 1995).

This links back to the earlier discussion on loneliness and isolation as coping resources can be found in the support network in which the person is embedded (Age UK, 2012). Psychological characteristics such as self-

confidence, self-efficacy and self-esteem can help the individual to determine what it is they need to draw upon. These coping responses affect the range of options perceived and increase the chance of coping effectively (Sugarman, 1995). This relates to the likely use of alcohol to cope in the absence of having these skills to draw upon.

Disruptions to the way our lives are normally conducted can trigger a response to that change; these are experienced more frequently due to the increased frequency of divorce and remarriage, increased job instability, geographic mobility and technological advancements. The reaction can be affected according to whether the change was expected, desired and pleasurable (Sugarman, 1995).

The transition to late adulthood (65-80) is not defined by age nor is it linked to a single universal event, the transitions have a range of 3-5 years either side and not every individual will hit the transition point at the same time in the same way. Episodes of illness, retirement, a reduction to sight and hearing may highlight the transition to late adulthood. This group experience an increase in illness and the death of those around them as well as their own health being affected, there is an acknowledgement of a loss of youth (Levinson, 1978). If poverty, unemployment and a lack of a satisfactory position in society has been the experience of early adulthood it is likely to have had an impact on the person in late adulthood as the focus will have been on survival rather than self-development. For the person in the late adulthood stage of their life there is little opportunity to correct any regrets or missed chances. There have been shifts in working longevity however with the retirement age ever increasing, it

could now be that the 60-year-old has another 15 years to make progress and right any regrets, late adulthood is still part of the working economy.

Society needs to consider what it does to facilitate the transition to late adulthood. The analogy of our trend to recycle old goods instead of taking them to the tip could be related to our older population in that although we do not take older people to the tip we do not do enough to recycle them (Erikson 1978). By speaking to and hearing older people's stories lessons can be learnt and this is something that does not happen when older people are lonely, isolated and lacking social skills or confidence. The integration with wider society does not naturally occur when older people live in accommodation removed from the general population. Those who are in their late, late adulthood (80 years plus) normally have few significant relationships with a life that holds very little meaning beyond that of personal comfort and their physical needs and yet they hold experience and wisdom relating to the life they have lived. Children can benefit from engagement with older people as it can cause them to stop and consider their own lives compared to that of the older person. The importance of intergenerational work relating to loneliness, isolation and alcohol consumption requires further research.

7.3.4 Retirement

It has been thought that retirement as a significant transition point may have an impact on older people's drinking behaviour. Harry (ID52) despite him experiencing depression after being made redundant he did not use alcohol to cope. For some people retirement is positively anticipated but it can also bring

with its stressors such as reduced income, loss of role and identity and a shrinking social network (Bamberger, 2015). Alcohol can be used to dampen the strain, to lessen the feelings associated with retirement and can be used to self-medicate against any anxiety or depression. The importance of social relationships should not be overlooked as they can establish behavioural and attitudinal norms, including acceptable drinking behaviours drawn from the cues within the social network where previously the work routine might have determined when it is acceptable to drink and retirement causes these to be removed (Bamberger, 2015). As discussed earlier continuity in a person's life supports stability from transition and those that struggle to adjust to the changes that retirement brings are less likely to cope and may use alcohol to do this. For most people patterns of alcohol use will go largely unaffected but it is important to understand the factors that determine this and how these interact. If retirement is viewed as a loss, drinking is likely to increase, if it is viewed with positivity and relief; increased alcohol consumption becomes less likely (Bamberger, 2015). It would seem that rather than attributing consumption of alcohol to a particular life event or transition there needs to be an understanding of the history that constructs the person to facilitate the prediction of alcohol use and the requirements for any treatment.

7.3.5 Locus of Control

It could be questioned whether the older people within this research have an active choice whether to consume alcohol or whether there were earlier life factors that increased their predisposition to use alcohol as an external coping mechanism. To this end the concept of control is an interesting phenomenon.

The sense of personal control is the belief that you can master, control and shape your own life and the opposite being a sense of powerlessness (Ross & Sastry, 1999). There is an understanding that this control can be within the person (internal) or with others or the environment (external) and as a continuum approach the degree of control can fluctuate depending on the situation (Rotter, 1954). This locus of control is a fundamental construct of psychology, essentially relating to the question of who or what controls life events (Neal, Weeks & Debattista, 2014). Knowledge of locus of control can help to contextualise health behaviours by predicting both what those health behaviours might be and the potential future health care utilisation (McPherson & Martin, 2016). Given that the research population is made up from older people who will be likely to have an increased demand for health and social care it would be prudent to gain some behavioural insight based upon locus of control. Not only might this predict certain behaviours leading to service uptake (such as high alcohol consumption) but it could also guide the type of information relayed and the methods employed to do so.

Individuals who have a high internal locus of control believe in their own ability to control themselves and have influence on the world around them. Percy (ID40) stated that he felt predisposed to alcohol misuse, he felt all his life that had little in common with those around him. These individuals hold a belief that the success or failures they experience are as a direct result of choices they make (Rotter, 1954). Those with high internal control will be more likely to try different approaches if their current repertoire of behaviour is not working (Ross & Sastry, 1999). Peggy (ID30) was brought up with her mum and dad and four siblings, despite having a troubled first marriage and a period of

depression that resulted in a hospital admission in her second marriage, her ability to cope came from her self-sufficiency and the focus on her children and grandchildren rather than the consumption of alcohol. When an individual holds the view that they have the ability to change things they are more confident and are increasingly likely to seek out information that will help them, they become motivated (Rotter, 1954). Those who have a strong internal locus of control cope better with change, experience better mental health and are less likely to experience depression, dysfunction and stress (Neal, Weeks & Debattista, 2014). Loss of control is an important feature of the disease model of addiction, the philosophy of treatment programmes such as alcoholics anonymous assert that alcoholics lack self-control and therefore by default the ability to make a choice whether to consume alcohol or not. Therefore, those who have a high internal locus of control are more able to control their dependence (McPherson & Martin, 2016). This seems to oversimplify addiction removing the acknowledgement of the addictive properties of alcohol and the fact the individual had chosen to drink in the first place. It is interesting to consider in relation to this research that the individual ability to self-moderate does in all likelihood relate to life events and how they impacted on the individual's ability to transition through life stages and why alcohol may be used as part of that coping tool set.

Individuals with a high external locus of control believe that control over events and other actions are outside of them. They believe that they have little control and may even believe that others have control over them, leaving them to only obey. James (ID48) described drinking as his partner, like his shadow that is always with him. This view removes that choice of whether he drinks or not,

he carries it with him at all times. This can lead to passivity and acceptance (Rotter, 1954). The individual with high external locus of control will have less success in changing their behaviours. They are less likely to see a connection between their own behaviour and any outcome as they do not believe they have control over their own destiny. There is a degree of fatalism in their approach often resulting in them giving up (Ross & Sastry, 1999). The development of coping skills and self-efficacy is viewed as wasted effort as the individual will have no influence over an externally located control (Ajzen, 2002).

Control has emerged as one of the most important concepts in psychology and is at the heart of successful childhood development and resilience (Mansell & Marken, 2015). An individual's locus of control develops in early childhood in part as a response to family values as well as forces outside the family (Neal, Weeks & Debattista, 2014). If a child is not socialised well or instilled with strong values then there can be a loss of self-esteem, lack of trust and social skills, development, emotional and intellectual problems and can result in drug and or alcohol abuse, mental illness, increased stress and lower future family cohesion (Henry, 2001). If the research population are considered in this context there were reports of separated parents, physical and sexual abuse, domestic violence, suicide and being raised by someone other than a parent (both informal and formal care arrangements). If the child has resilience then their capacity to meet a challenge and use it for psychological growth increases for example the ability to overcome negative thoughts, or to gain value from others when not receiving it from parents (Henry, 2001). This would then cast some light onto the actions and behaviours of the research population when

unable to establish self-esteem, resilience and self-efficacy the result is a high external locus of control. There were reports of alcohol, work, travel and partners being the control in an individual's life. The perception of not having internal control could contribute to the individual not being able to transition through life stages in a way that would facilitate progression and cause a default behaviour back to what is comfortable and familiar such as the consumption of alcohol.

Older people have a lower sense of control than younger people and that perceived control decreases with age at an accelerating rate. This has been attributed to the loss of meaningful relationships, a deterioration of health and physical functioning and an increase in dependency especially upon health and social care (Ross & Sastry, 1999). It would make sense for older people to become engaged in the wider society in order to facilitate the development and sustainability of the internal locus of control or at the very least a reduction in the level of reliance on the external locus of control, to get the continuum to move slightly. To recycle the worth of an older person back to society could reduce dependency on external controls such as alcohol and health and social care.

7.4 Chapter Summary

This chapter has presented a discussion of the Study 2 results under the themes of domestic violence, work, family, social contact and mental health. The chapter has linked the findings to the literature with discussion of older people's alcohol use, isolation and loneliness, life transitions, retirement and locus of control. Much of the current literature acknowledges that there is little

qualitative research on older people and alcohol use and yet there is a continued dialogue around the reasons older drink including bereavement, retirement, loneliness and isolation, homelessness and depression (Holley-Moore & Beach, 2016). The factors determining why older people drink are multifaceted and complex and are indicative of more than one isolated life event. Although this research does not provide explicit answers to the question of factors determining decisions to drink it does provide some clarity on the broad headings referred to frequently in the current literature.

Chapter 8 Reflection

As part of the research process the subject of researcher reflection was considered in some depth. The researcher was approaching the world of academic research from a unique multifaceted perspective. Each of the professional roles that the researcher experienced had reflection as part of the core practice. The researcher was a senior nurse with 23 years' experience; a public health practitioner and a doctoral student. This chapter will consider the professional requirements of each profession in terms of reflection; the impact that reflection has had on the research completed for this thesis but the chapter will begin by highlighting what reflection actually is and the principle function of it.

8.1 What is reflection?

To reflect on a situation is more than a description, if any learning is to come from an experience there needs to be exploration and explanation of the event being reflected upon. By reflecting back, often those things that might have been difficult to admit can be talked about with a clarity of truth, anxieties can be revealed and a balanced judgement of strengths and weaknesses applied (effective learning service, 2008).

A deeper reflection of your experiences allows further insights from your work, leading to a critical review of your own behaviour, that of others or the product of that behaviour (Walton, 2001). Reflection asks us to think about our practice and ideas and then it challenges us to take a step back and examine our practice (Kenny, 2010). Reflection can often challenge assumptions, biases

and questions of personal behaviours. This was vital during the interview process of this doctoral research so that any personal assumptions and bias could be acknowledged in order to try and prevent transference. To reflect is not about creating a product as such but is about self-exploration and self-illumination (Hampton, 2016). It has been noted that reflection can tell the truth while accepting the impossibility of objectivity but that it is from the thoughts and feelings emerging from the reflection that generalisations or concepts can be generated (Gibbs, 1998). In practice reflection is not about retelling an event but considering what emotions were evoked, what could have been improved, what was learnt, and what impact the event had. There are frameworks developed to aid reflection for those who require a guide but for some professions the practice of reflecting becomes second nature.

8.2 Reflection in nursing

It could be argued that nursing is one such profession where reflection becomes second nature. The doctoral researcher has been a qualified nurse since 1998; who achieved a distinction in her practice when studying to become a nursing sister. Reflection has always been part of her practice even as a student nurse prior to qualification. Reflection is used in a number of ways; after a critical incident or trauma; after a death; when something goes really well. It is a tool commonly used in nursing clinical practice to demonstrate everyday learning and the processing of thoughts (Berksby, 2015). Reflection is now part of the requirements of the Nursing and Midwifery Council's revalidation process for all qualified registered nurses. Although reflection is

generally about looking back there does need to be a forward-looking step in order to add value and make it worthwhile (Berksby, 2015).

The Royal College of Nursing principles of nursing practice (2017), detail eight key principles that help nurses to reflect on their own practice and develop as a professional. They include principles such as 'taking responsibility and answering for their own judgements and actions and that nurses lead by example, develop themselves and other staff and influence the way care is given'. The RCN, (2016) stated that as a nurse you should 'act to uphold the reputation of your profession at all times, you should be a model of integrity and leadership for others'. As a nursing professional this had a potential impact on the interviews carried out as it was virtually impossible to remove the developed nursing perspective. The fact that the researcher was still registered as a nurse meant that she was thereby governed by the regulations and responsibilities of the Nursing and Midwifery Council. The fact that the researcher was a nurse was made clear to each interviewee as potentially this meant that any information disclosed where it was felt that the interviewee was at risk would have to be reported under the duty of care. For example, those who scored high on their audit scores were advised that the scores would be shared with their GP where there was professional concern or they were advised to see their GP (consent was gained for this however a nursing professional can pass information without consent). This would go beyond the position normally taken by a researcher who might offer advice to the interviewee and take no further action. Initially it was considered whether this disclosure to the interviewees might cause them to withhold information but it

appeared that nursing is still a trusted profession and so there was not a noticeable impact.

As a nursing professional there is an RCN principle (2017) that mentions being 'at the heart of the communication process, to handle information sensitively and report things you are concerned about'. The fact that the researcher has extensive experience of communicating with people in some of the most difficult of circumstances (end of life care for example), that the skills required to quickly build rapport were well established. As a district nurse care is provided for an individual in their home, often meeting people for the first time, sometimes in traumatic or distressing circumstances; there needs to be an ability to build trust, show professional competence and knowledge whilst treating each person with compassion and sensitivity often in a very short space of time. These were skills that were transferrable when interviewing participants. This facilitated a good relationship with the interviewees and was likely to have contributed to the candour of the discussions captured. The previous experience of the researcher resulted in a good ability to evaluate safety and put mechanisms into place to protect herself and those being interviewed.

8.3 Reflection in public health

Reflection is considered good practice and is an expected part of continuous professional development within public health (Jayatilleke & Mackie, 2012). The ultimate aim of reflection is to improve practice via reasoned thought and critical assessment. It should not be a tick box exercise but a unique and

personal response to experiences, situations and events (Syed, 2012). There is no right or wrong in reflective thinking but it is very important to establish your own baseline position. This involves the revisiting of your previous experiences and knowledge and to consider how and why you think the way you do. The examination of your beliefs, values, attitudes and assumptions forms the foundations of your interpretation of events. Being able to reflect is central to becoming a critical professional who is prepared to challenge practice (Syed, 2012). During the research process it was important that the researcher fully considered and accounted for her professional position with regards to alcohol consumption. Although the researcher was part of the public health team who reviewed alcohol licensing applications she did not work directly with the drugs and alcohol team. This meant that the professional views of the researcher were less likely to cause a bias with the interviewees when talking about their own drinking behaviours.

Chapter 9 Conclusions and recommendations

9.1 Introduction

This chapter provides an overview of the research, highlighting the main findings, the contribution to knowledge and the implications of the findings from Study 1 and Study 2 for both policy and further research.

This research explored drinking among older people living in sheltered accommodation and the factors that might determine the decision to drink. As far as the research shows this is the first study to investigate alcohol consumption in this unique population. The research used both qualitative and quantitative methods to gain insight into the prevalence of alcohol consumption and the factors which older people perceive to have influenced their decisions to drink.

The findings from Study 1 showed that anecdotal reports of high levels of alcohol consumption in this population of older people living in sheltered accommodation were not supported by this research population. Over 86% of respondents were in the low risk category of drinking (0-7 points), a higher percentage than the UK older population where 80% of older people are in the lower risk group (Giles, 2016). Six percent (due to the small sample this is actually under four people) of those in this research sample scored 16+ on the AUDIT score compared to three percent nationally. Findings from Study 2 show that there are several contributing factors that can be both protective and contributing when people drink including mental health, domestic violence, family, work and social contact. This research has also highlighted the

potential usefulness of a life-course perspective in appraising the role of past experiences as an influencer in current behaviour in relation to drinking choices. Case studies relating to the importance of the life course and the impact that the locus of control can have has been developed and presented within this research (see Chapter 6).

9.2 Recommendations 9.2.1 Public policy

Public policy is currently failing to provide a coherent strategy to combat alcohol related harm in older adults. There are no strategies or policies identifying the needs of older adults in England or Scotland causing regional inconsistency as Wales and Northern Ireland have strategies in place. Wales has the 'Welsh Strategy for Older People 2013-23 (2013), and Northern Ireland have the New Strategic Direction for Alcohol and Drugs 2011-2016 (2011). English Government policies and strategies fail to recognise the association between alcohol-related harm and other areas such as social isolation and loneliness, life transitions such as retirement and age related cognitive impairment such as dementia (Holley-Moore & Beach, 2016). An age defined approach to strategies looking to reduce alcohol related harm is needed due to the increasing older population and the subsequent demand placed upon health and social care. Older adults disproportionately cost more to treat for alcohol-related harm than younger generations (Alcohol Concern, 2011).

9.2.2 Public health campaigns

The main focus of alcohol awareness has been the use of alcohol units and recommended limits on consumption, previous research has highlighted that

older people are the group who are most likely to lack knowledge of what these units and limits are (McInnes & Powell). On 8th January 2016 the four-home nation's Chief Medical Officers proposed new recommended alcohol guidelines and older people were considered in relation to this, however the new guidelines adopted were not age specific (DoH, 2016). Without UK wide collective recommendations, the messages for older people run the risk of becoming increasingly confusing. An older person specific unit guide should be developed and implemented.

9.2.3 Staff awareness

There is a lack of awareness of the need to screen for alcohol consumption and alcohol related harm amongst health and social care professionals resulting in an increased risk that alcohol related harm in older people is not being detected (Public Health England, 2016). Alcohol use in older people is generally accepted to be less prevalent than in younger groups (Dawson, 2009) but this could be due to poor detection coupled with the reluctance of professionals to screen and refer older people on to treatment services compared where required, to that of younger people (McInnes & Powell, 1994; Johnson, 2000; Kaner et al, 2001).

Often symptoms are attributed to delirium; age related cognitive impairment or medication side effects (Wilson et al, 2013). There needs to be improved staff training for GPs, community nursing and social care teams as well as the housing staff on site within sheltered accommodation relating to the screening of older people for alcohol use including appropriate advice and if required

onward referral. The training would benefit from being broader than just how to use the screening tools but the implementation of them including how to have a difficult conversation. Barriers have included a lack of skills and knowledge, lack of training, attitudes to alcohol use by health professionals, queries as to the appropriateness of use in community settings (Wilson et al, 2013a). This additional training would potentially increase the identification of those older people who consume over the advised alcohol limits.

9.2.4 The oldest of the old

Those aged 80 and above have traditionally been a small segment of the population but their numbers are increasing, as is their proportion of the population (Giles,2016). This age group have specific characteristics which can affect drinking behaviours, they are likely to be increasingly frail; or disabled with an increased risk of falls as well an increased likelihood of dementia or poor health in general (Giles, 2016). These factors make it difficult for this population group to attend health appointments or access service provision. An increasing proportion of older people are providing unpaid care, or are widowed (ONS, 2011). If this group are also consuming alcohol above the recommended limits then they could become increasingly unsteady on their feet, contributing to the risk of a fall. Alcohol could interact with medications and cause increased levels of confusion (RCP, 2015). In order to provide information and support to this age group there is the need for strategies and policies to be tailored to them over and above that for older adults otherwise they run the risk of not being provided for. Policy should consider the move away from a one size fits all model of alcohol management

to a more individualised approach to support the adjustment of later life events. The older old are harder to reach due to their isolation. As the results of this research have highlighted the social contact and family interactions vary among older people and can impact the perception of risky drinking behaviours.

9.2.5 Housing support

Recent austerity cuts have affected health and social care as well as that of local authorities; this has resulted in a reduced input of Sheltered Housing Officers (wardens) into the sheltered housing service (HM Treasury, 2014). This research has highlighted the importance of a person's self-control and self-efficacy when considering whether to drink. These factors coupled with life circumstance such as retirement, social isolation and loneliness could determine whether an older person drinks alcohol. As a person ages support networks can become smaller and it would seem that the sheltered housing officers are one group who could help to identify hazardous or harmful alcohol consumption and to facilitate action to counter it. Study 2 highlighted that social isolation, loneliness and mental health were factors in determining the decision to drink and therefore it would be logical to increase the contact that older people experience. A 10 question AUDIT assessment coupled with a 13-question locus of control assessment during the sheltered housing annual care planning process could identify those at increased risk of alcohol consumption (Rotter, 1954; Babour, Higgins-Biddle, Saunder et al, 2001). This would allow for the older person to receive care from social services, health and housing tailored to their needs at a low cost to the provider.

9.2.6 Socio-economic status

About one fifth of people aged 65 and over rent their home from a local authority (Giles, 2016). According to the Ministry of Housing, Communities and Local Government (2017), 28.2% of those aged 55 and above, who rent from a local authority are retired with 42.3% are living in single persons households. The mean household income for those renting from a local authority was £17,393. Housing benefit is received by 48% of local authority tenants aged 55 and above suggesting that the research population were of lower socio-economic status. People who consume alcohol and are of a lower socio-economic status tend to experience higher levels of alcohol-related harm (Alcohol Research UK, 2015). Reasons cited for this include inequality in accessing health and social care services, different drinking patterns and engaging in other unhealthy lifestyle choices such as smoking and a poor diet (Alcohol Research UK, 2015). As a result, prevention and treatment programmes, public health initiatives and alcohol harm prevention policies should ensure they take account of the needs of older adults in more deprived areas such as those in this research study who were all living in local authority rented sheltered accommodation (Holley-Moore & Beach, 2016).

9.3 Limitations

The sample size of Study 1 may mean that the sample was not representative of the wider older population in sheltered accommodation. The research was based in one city within the North East which in itself may not be typical. Nonetheless the research has contributed to the wider body of knowledge.

The sampling for Study 1 although methodologically supported could not take into account the refurbishment schedule changes from the local authority. This affected the population that were available and could have had impact upon the research. Many older people were at risk of being displaced from the homes while the building work was completed and therefore may not have engaged in the research process.

The use of self-reporting of alcohol consumption could result in under reporting of alcohol use.

There could have been a misunderstanding of alcohol guidelines. Although the unit guide was placed onto the survey there was an assumption that the older person would understand what a unit was.

9.4 Future Research

9.4.1 Investigate the levels at which the sheltered housing population are consuming alcohol.

The North East of England has a significantly older population and higher rates of harmful and hazardous drinking than the rest of England coupled with being the poorest region in England with the lowest life expectancy at age 65 (Lock et al, 2012). The North East has 12 of the top 20 binge drinking communities in England and the highest alcohol related hospital admissions in England (Lock et al, 2012). Newcastle City Council (2013), responsible for the area in which this research was conducted, has stated that the ageing population is one of the key demographic challenges that will impact on the type of housing

required in the city. With assistance given to people to remain independent for longer, preventing or delaying the need for more costly interventions from both health and social care is vital.

9.4.2 Comparison of sheltered accommodation and the general population.

A replication of both the qualitative and quantitative studies including a survey of alcohol use and investigation of the factors determining the decision to drink would be beneficial in both the sheltered housing environment and the older, general housing population on a larger scale to see if the results of this research can be applied to other participants and circumstances. This would test if the same study was conducted again would a differing social, economic and political conditions impose a different outcome. A different culture and geographic location might have an impact on the outcome. This would give a good view of older person's drinking behaviour across housing tenures and could potentially influence the commissioning of services and public health messages.

9.5 Conclusion

Alcohol use in later life has, until recently received little attention. Among older people psychosocial factors including bereavement, retirement, boredom, loneliness, and depression are all associated with higher rates of alcohol use (Holley-Moore & Beach, 2016). In particular, the loss of a home has been compared to bereavement; therefore, where older people live is likely to have an impact on the quality of their lives (Tinker, 1997).

This research found that older people who are living in sheltered accommodation did not report drinking at higher levels than the general population. The fact that they are visible for health and social care service may cause anecdotal reporting of high levels of drinking. Older people's lives do not simplify as they age and therefore the reasons for using alcohol are complicated and individualised. They are influenced by early life experiences, traumatic or life changing events as well as the strength of the person's internal locus of control. This work has identified that locus of control is an important issue in the decisions to drink. Future work into the impact that a person's locus of control, either internal or external has on the likelihood to use alcohol would assist in the delivery and effectiveness of behavioural change theories.

References

Abrams, D., Abraham, C., Spears, R. and Marks, D. (1990) *AIDS: invulnerability: relationships, sexual behaviour and attitudes among 16-19 year olds*. In: Aggleton, P., Davis, P. & Hart, G. *AIDS: Individual, cultural and policy dimensions*. London: Falmer press.

Acheson, D. (1998). *Independent inquiry into health inequalities*. The Stationery Office: London.

Adams, W. (1996). Alcohol use in retirement communities. *Journal of American Geriatric Society*. 44(9) 1082-5.

Age Concern. (2007). *Improving services and support for older people with mental health problems: The second report from the UK inquiry into mental health and well-being in later life*. Age Concern.

Age UK. (2012). *Loneliness: The state we're in*. Age UK

Ajzen, I. (2002). Residual effects of past on later behaviour: habituation and reasoned action perspectives. *Personality and Social Psychology Review* (6) 107-122.

Ajzen, I. (2002) Perceived behavioural control, self-efficacy, locus of control and the theory of planned behaviour. *Journal of Applied Social Psychology*. 32(4) 665-683.

Ajzen, I. (1991) The Theory of Planned Behaviour. *Organizational Behaviour and Human Decision Processes*. 50 (2):179-211

Ajzen, I. (1988) The theory of planned behaviour. *Organisational Behaviour and Human Decision Processes*. 50, 179-211.

Ajzen, I. & Fishbein, M. (1980). *Understanding attitudes and predicting social behaviour*. Prentice Hall.

Alcohol Alert. (2005). Screening for alcohol use and alcohol related problems: alcohol research and health. *US Department of Health and Human Services*. 28 (2).

Alcohol Concern. (2002). *Alcohol in older people*. Alcohol Concern.

Alcohol Concern (2011). *Alcohol and older people in Wales*. Alcohol Concern.

Alcohol Research UK (2015) Understanding the alcohol harm paradox. Alcohol Research UK. London.

Alexander, F. & Duff, R. (1988). Social interaction and alcohol use in retirement communities. *The Gerontologist*. 28(5): 632-636.

Allan, G., & Skinner, C. (1993) *Handbook for research students in the social sciences*. The Flamer Press. London.

Allen, J.P., Litten, R.Z., Fertig, J.B. and Babor, T. (1997) A review of research on the Alcohol Use Disorders Identification Test (AUDIT). *Alcoholism: Clinical and Experimental Research* 21(4): 613-619.

Atkinson, P., Coffrey, A., Delmont, S., Lofland, J., Lofland, L. (2013). *Handbook of ethnography*. 3rd edition. Sage.

Babour, T., Higgins-Biddle, J., Sanders, J., & Monterio, M,. (2001). *The alcohol use disorders indentification test*. 2nd edition. World Health Organisation.

Baird, A. (1999) Introduction to qualitative research. *Practice Nursing*. 10(8):16-19.

Bamberger, P. (2015) Winding down and boozing up: The complex link between retirement and alcohol misuse. *Work, Ageing and Retirement*. 1(1): 92-111.

Bandura, A. (1986) *Social foundations of thought and action*. Prentice Hall: New Jersey.

Barnot, J. (2008) Biographical methods in Lasuvtari, A., Bickman, L., Branner,J. (2008) *The sage book of social research methods*. London 344-356.

Baumeister, R. & Leary, M. (1997). Writing narrative literature reviews. *Review of General Psychology*. (1) 3 311-320.

Becker, H. (1990) *Symbolic interaction and cultural studies*. University of Chicago Press. Chicago.

Bell, A. (2005). "Ah yes, I remember it well", reflections on using the life grid in qualitative interviews with couples. *Qualitative Sociology Review*. 1(1): 51-67.

Bell, J. (1999). *Doing your research project*. 3rd edition. Open University Press: Buckinghamshire.

Berkowitz, A. (2005). *An overview of the social norms approach* in Lederman, L. and Stuart, L. *Changing the culture of college drinking: A socially situated health communication campaign*. Hampton Press: New Jersey.

Berks, J. & McCormick, R. (2008). Screening for alcohol misuse in elderly primary care patients: A systematic literature review. *International Psychogeriatrics*. 20 1090-1103.

Berney, L. (2003). The life grid method of collecting retrospective information from people of older ages. *Research Policy and Planning*. 2(2) 13-22.

Blood, L. (2002). *Sheltered housing and the resettlement of older homeless people. Briefing paper on a report for help the aged / HACT*. Help the Aged. London.

Brewer, J. (2000). *Ethnography*. Open University Press.

Brown, J. (1958) Some tests of the decay theory of immediate memory. *Quarterly Journal of Experimental Psychology*. 10, 12-21.

Bruner E M (1984). Introduction: The opening of anthropology. In S Plattner & E.M. Bruner (Eds), *Text, Play, and story: The construction and reconstruction of self and society – 1983 proceedings of the American ethnological society* (pp 1-16) Princeton, NJ: American Ethnological Society.

Bryant, A. & Giyeon, K. (2013). The relationship between frequency of binge drinking and psychological distress among older adult drinkers. *Journal of Ageing and Health*. 25(7) 1234-1257.

Burr, V. (1995) *An introduction to social constructionism*. Routledge. London.

Central Office for Research Ethics Committees (2007) *Qualitative protocol guidance*. www.hra.nhs.uk Accessed 20/01/2017

Conger, J. (1956) Reinforcement theory and the dynamics of alcoholism. *Quarterly journal of studies on alcohol* 17. 296-305.

Cooke,R., Dahdah,M., Norman,P. & French,D. (2016) How well does the theory of planned behaviour predict alcohol consumption?: A systematic review and meta-analysis. *Health psychology review*. Vol10. No2. 148-167.

Connor, M. & Norman, P. (2005) *Predicting health behaviour*. 2nd Edition. Open University Press.

Council on Scientific Affairs, American Medical Association (1996) Alcoholism in the elderly. *JAMA* 275, 797-801.

Crane, M & Warnes, A.M. (2001) Older people and homelessness: prevalence and causes. *Topics in Geriatric Rehabilitation*, 16, 1-4.

Creswell, J. & Clark, V. (2007) *Designing and conducting mixed methods research*. Sage publication.

Crome, I., Dor, K., Janikiewi, Z. & Tarbulc, A. (2013) *Our invisible addicts*. Royal College of Psychiatrists.

Crome, I. (2000) Alcohol and the older person. *In Drugs and the older population*. 1191-1204. Imperial College Press.

Crotty, M. (1998) *The Foundations of social research, meaning and perspective in the research process*. Sage.

Cutler, D. (2012) *Tackling loneliness in older Age: The role of the arts*. The Baring Foundation.

Dahlgren, G. & Whitehead, M. (1991) *Policies and strategies to promote social equity in health*. Stockholm Institute for Further Studies.

Daly,H., Thompson,K., Kearney,M., Lagord,C., Waterfall,J., Berkley-Patton,J., Posser,E. & McCluskey-Fawcett,K. (2017) *NHS health check best practice guidance*. Public Health England.

Dawson, D. (2009) Low risk drinking limits: Absolute versus relative risk. *Addiction*. 104.1303-1304.

Denscombe, M. (2007) *The good research guide*. 2nd Edition. Open University Press: Maidenhead.

Denzin N K (1989). *Interpretive Biography*. Sage Publications, London

Denzin, N. & Lincoln, S. (2003) *Collecting and interpreting qualitative materials*. 2nd Edition. Sage Publications: Thousand Oaks.

Department of Health. (2016) *UK Chief Medical Officer's alcohol guidelines review- report from the guidelines development group to the UK Chief Medical Officers*. DoH: London.

Department of Health (2013) *Public health outcomes framework. Healthy Lives, Healthy People*. DoH: London.

Department of Health (2011) *Northern Ireland new strategic direction for alcohol and drugs 2011-2016*. DoH NI.

Department of Health (2002) *Choosing health: Making healthy choices easier*. The stationary office: London.

Department of Health. (2006) *Our health, our care, our say*. DoH: London.

Department of Health (1999) *Saving lives: Our healthier nation*. The Stationery Office: London.

Department of Health (1990) *National Health Service and Community Care Act*. The Stationery Office. London

Dunne, F. J & Schipperheijn, J. A. M. (1989) The gerontology alcohol project: a behavioural treatment program for elderly alcohol abusers. *Gerontologist*. 24, 510-516.

Elderly Accommodation Council. (EAC). (2012) *Statistics on specialist housing provision for older people in England*. EAC: London.

Erikson, E. (1978) *Adulthood*. WW Norton and Company. London.

Ewing, J. (1984) Detecting alcoholism the CAGE questionnaire. *JAMA*. 252
1905-1907

Faculty of Public Health (2010) What is Public Health? Available at www.fph.org.uk accessed 12/06/2014

Fiellin, D., Carrington, R. & O'Connor, P. (2000) Screening for alcohol problems in primary care: A systematic review. *International Medicine*. 160,
1977-1989.

Frank A W (2000). 'The standpoint of the story teller', *Qualitative Health Research*, Vol. 10 No.3, pp.354-365

Fudge, N., Wolfe, C., McKeivitt, C. (2007) Involving older people in research. *Age and Ageing*. 36(5) 492-500.

Fuller, E., Jotangia, D. & Farrell, M. (2007) Alcohol misuse and dependence in
Mamanus, S., Meltzer, H., Brugha, T., Bebbington, P., Jenkins, R. (2007) *Adult psychiatry morbidity in England, 2007 results of a household survey*. NHS information centre for health and social care.

Gale, N., Heath, G., Cameron, E., Rashid, S., & Redwood, S. (2013). Using the framework method for the analysis of qualitative data in multidisciplinary health research. *BMC Medical Research Methodology*. 13, 117.

Giles, A. (2016) *Older people and alcohol misuse: helping people stay in their homes*. |Housing Lin. London.

Gilhooly, M. (2005) Reduced drinking with age: is it normal? *Addiction Research Theory*. 13(3) 267-280.

Glaser, B. (1992) *Basics of grounded theory analysis*. Sociology Press. Mill Valley CA.

Goodman, A., Adams, A. & Swift, H. (2015) *Hidden citizens: how can we identify the most lonely older adults?* The Campaign to End Loneliness. London.

Grant, B. & Gidding, L. (2002) Making sense of methodologies: a paradigm framework for the novice researcher. *Contemporary Nurse*. 13 10-28.

Guba, E. (1990) The alternative paradigm dialogue in Guba, E. *The paradigm dialogue*. Sage: Newbury Park.

Guba, E. & Lincoln, Y. (1994) Competing paradigms in qualitative research in Denzin, N. and Lincoln, Y. *Handbook of qualitative Research*. Sage: London.

Hajat, S., Haines, A., Bulpitt, C. and Fletcher, A. (2003) Patterns and determinants of alcohol consumption in people aged 75 Yrs and older: results from MRC trial of assessment and management of older people in the community. *Medicine, Age and Ageing*. 33(2) 170-177.

Hammersley, M. (1992) *What's wrong with ethnography?* Routledge London.

Hancock, T. (1993) Health, Human development and the community ecosystem: three ecological models. *Health Promotion International*. Vol 8 No1 41-47.

Havari, E., Mazzonna, F. (2015) Can we trust older people's statements on their childhood circumstances: Evidence from sharelife. *European Journal Population*. 31 233-257.

Health and social care information centre. (2015) *Statistics on alcohol: England, 2015*. Health and social care information centre

Henry, D. (2001) Resilient children: what they tell us about coping with maltreatment. *Social Work in Health Care*. 34 No.314 283-298.

Herring, R. & Thom, B. (1997) Alcohol misuse in older people: the role in of home carers. *Health and Social Care in The Community*. 5 (4) 237-245.

Hirata,E., Nakons, E., Pinto, J., Litvoc, J. & Bottino.C. (2009). Prevalence and correlates of alcoholism in community- dwelling elderly living in Sao Paula, Brazil. *International Journal of Geriatric Psychiatry*. 24 1045-1053.

HM Government (1998) *The Data Protection Act*. The Stationery Office. London.

HM Government (2012) *The Government's alcohol strategy*. The Stationary Office.

HM Treasury (2014) *Charter for budget responsibility autumn statement*. The Stationary Office.

Hoeck, S. & Van Hall, G. (2012) Unhealthy drinking in the Belgian elderly population: prevalence and characteristics. *The European Journal of Public Health*. 23(6) 1069-75

Hoinville,G. & Jowell,R. (1978) *Survey research practice*. Heinemann Educational books Ltd.

Holland, P., Lee, B., Blane, D. & Doney-Smith. G. (1999) The life grid method in health inequalities research. *Health Variation*. 3: 8-9.

Holley-Moore, G., & Beach, B. (2016) *Drink wise, age well: Alcohol use and the over 50s in the UK*. ILC. London.

Holloway, S., Jayne, M. & Valentine, G (2008) 'Sainsbury's is my local': English alcohol policy, domestic drinking practices and the meaning of home. *Transactions of the institute of British geographers*. 33. 532-547.

Housing Care. (2010) www.housingcare.org.uk accessed 28/02/2011

Hughes, J. (1994) *The philosophy of social research*. 2nd Edition. Longman.

Institute of Alcohol Studies IAS Factsheet. (2009) *The impact of alcohol on the NHS*. IAS.

Institute of Alcohol Studies. (2009) *Alcohol and the elderly*. www.ias.org.uk. Accessed 28/02/2011

Janz, N. & Becker, M. (1984) The health belief model: A decade later. *Health Education Quarterly*. 11(1) 1-47.

Johnson, L. (2000) Alcohol problems in old age: A review of recent epidemiological research. *International Journal of Geriatric Psychiatry*. 15 575-581.

Jones, S., Carley, S., & Harrison, M. (2004) An introduction to power and sample size estimation. *Emergency Medicine Journal*. 20(5) 453-458.

Jones, L. & Sumnall, H. (2016) *Understanding the relationship between poverty and alcohol misuse*. Liverpool John Moores University Centre for Public Health

Joseph Rowntree Foundation. (2009) *Drinking in the UK: An exploration of trends*. Joseph Rowntree Foundation.

Jvett, L. (2012) *Responding to the challenge of alcohol related harm in the South West*. The South West Public Health Observatory.

Kaner, F., Heather, N., Broadie, J., Lock, L. & McAvoy, B. (2001) Patient practitioner characteristics predict brief alcohol intervention in primary care. *British Journal of General Practice*. 51(471) 822-827.

Kirk, J. & Millar, M. (1986) *Reliability and validity in qualitative research*. Sage Publications. Beverly Hills.

Kiteley, R. & Stogdon, C. (2014) *Literature reviews in social work*. Sage: London.

Koster, A., Bosma, H., Broesevan-Groenou, M et al (2006) Explanations of socioeconomic differences in changes in physical function in older adults: results from the longitudinal aging study Amsterdam. *BMC Public Health*. 6, 244

Kuipers, M., Jongeneel-Grimen, B., Droomer, M., Wingens, M. et al (2013) Why residents of Dutch neighbourhoods are less likely to be heavy drinkers: the role of individual and contextual characteristics. *Journal of epidemiology and community health*. 67 587-594.

Lader, D. & Steel, M. (2009) *Opinions survey report No 42 drinking: Adults behaviour and knowledge in 2009, A report on research using the national statistics opinions survey produced on behalf of the NHS information centre for health and social care*. Office for National Statistics.

Lakhani, N. (1997) Alcohol use amongst community dwelling elderly people: A review of the literature. *Journal of Advanced Nursing*. 25 1227-1232.

Landsbergis, P., Grzywacz, J., Lamontagne, A (2014) Work organisation, job insecurity and occupational health disparities. *American Journal of industrial medicine*. 57. 495-515.

Lang, L. & Melzer, D. (2009) Moderate alcohol consumption in later life: time for a trial? *The American Geriatrics Society*. 57 (6) 1110-1112.

Lang, L., Guralnik, J., Wallace, R. & Melzer, D. (2007) What level of alcohol consumption is hazardous for older people? Functioning and mortality in US and English national cohorts. *The American Geriatrics Society*. 5(5) 49-57.

Lang, L., Wallace, R., Hillppert, F. & Melzer, D. (2007) Moderate alcohol consumption in older adults is associated with better cognition and well-being than abstinence. *Age and Ageing*. 10, 1093.

Lee, C. Cramotnev, H. (2007) Life transitions and mental health in a national cohort of young Australian women. *American Psychological Association*. 43(4) 877-888.

Levinson, D. (1978) *The seasons of a man's life*. Ballantine. London.

Lincoln, Y. & Guba, E. (1985) *Naturalistic inquiry*. Sage Publications: London.

Ling, J., Smith, K., Wilson. G., Brieley-Jones, L., Crosland, A., Kaner, E. & Haighton, C. (2012). The 'other' in patterns of drinking: a qualitative study of attitudes towards alcohol use among professional, managerial and clerical workers. *BMC Public Health*. 12(892).

Lock, C., Wilson, G., Ling, J., Smith, K., Crosland, A. & Kaner. E. (2012). *Alcohol risk and harm in later life: A needs assessment In South of Tyne and Wear*. Age Concern.

Mansell, W., & Marken, R. (2015) The origins and future of control theory in psychology. *Review of General Psychology*. 19(4) 425-430.

Marmot, M. (2010) *Fair society, healthy lives: The marmot review*. The Marmot Review. London.

Matteson, F., White, H., Moineddin, R et al (2011) Drinking in context: the influence of gender and neighbourhood deprivation on alcohol consumption. *Journal of epidemiology and community health*. 66. Doi 10.1136/jech.2010.112441.

Maxwell, J. (1996) *Qualitative research design: an interpretive approach*. London. Sage publications.

McCrum-Gardiner, E. (2010) Sample size and power calculations made simple. *International Journal of Therapy and Rehabilitation*. 17(1) 10-14.

McInnes, E. & Powell, J. (1994) Drug and alcohol referrals: Elderly substance abuse diagnoses and referrals being missed? *BMJ*. 308 444-446.

McMurdo, M., Roberts, H., Parker, S. et al (2011) Improving recruitment of older people to research through good practice. *Age and Ageing*. 40 (6) 659-655.

McPherson, A. & Martin, C. (2016) Are there gender differences in locus of control specific to alcohol dependence? *Journal of Clinical Nursing*. 26 258-265.

McVeigh, T. (2013) Older people are abusing alcohol more than the young. *Www. The guardian.com*. Accessed 19.9.13.

Mills, N., Daker-White, G., Graham, A., & Campbell, R. (2006) Population screening for Chlamydia trachomatis infection in the UK: A qualitative study of the experiences of those screened. *Family Practice*. 23(5) 550-557.

Ministry of housing, communities and local government (2017) *Social and private renters, 2015-16*. [WWW.gov.uk](http://www.gov.uk) Accessed May 2018.

Mirand, A. & Welte, J. (1996) Alcohol consumption among elderly in a general population: Erie County New York. *American Journal of Public Health* 86(7) 978-984.

Moore, A.A., Endo, J.O & Kalin, M. (2003) Is there a relationship between excessive drinking and functional impairment in older persons? *Journal of American Geriatrics Society*. 51, 44-49.

Moos, R., Schulte, K., Brennan, P. & Moos, B. (2009) Older adult's alcohol consumption and late life drinking problems: A 20 year perspective. *Addiction*. 104 1293-1302.

Moy, I., Frisher, M., Crome, P., et al (2011) Systematic and narrative review of treatment for older people with substance problems. *European Geriatric Medicine*. 2(4) 212-236.

Murphy, J., Arxar, S. & Belgrave, L. (2010) The life Course Metaphor, Implications for Biography and Interpretive Research. *Qualitative Sociology Review*. 6(1).

National Institute on Alcohol Abuse and Alcoholism. (1995) *The physicians guide to helping patients with alcohol problems*. NIAAA.

Neal, M., Weeks, G., & Debattista, J. (2014) Locus of control: A construct that warrants more consideration in the practice of couple therapy. *The Family Journal: Counselling and Therapy for Couples and Families*. 22(2) 141-147.

Newcastle City Council. (2013) *Licensing act 2003 statement of licensing policy 2013-2018*. NCC.

Newcastle City Council. (2012) *Newcastle an age friendly city: older people's housing delivery plan 2013-18*. NCC.

NHS England (2017) *Quick guide: Health and Housing: Improving health through the home*. Public Health England.

Nursing and Midwifery Council. (NMC) (2008) *The code of professional conduct*. London.

Nutbeam, D. (1998) *Health promotion glossary*. WHO.

O'Connell, H., Chin, A., Cunningham, C. & Lawlor, B. (2003) Alcohol use disorders in elderly people: Redefining an age old problem in old age. *British Medical Journal*. 327, 664-667.

Office for National Statistics (2017a) *Opinions and Lifestyles Survey: adult drinking habits in Great Britain*. www.ons.gov.uk Accessed 18 May 2018.

Office for National Statistics (2017) *Adult drinking habits in Great Britain: 2005-2016*. www.ons.gov.uk Accessed 14/04/2017.

Office for National Statistics (2011) *What does the 2011 Census tell us about the 'oldest old' living in England and Wales*. www.statistics.gov.uk Accessed 24/02/2017.

Office for National Statistics. (2008) *General household survey*. ONS. London.

Office for National Statistics. (2008) *National statistics online – focus for older people* www.statistics.gov.uk accessed 28/02/2011.

Ong, A., Bergeman, C. & Boker, S. (2009) Resilience comes of age: defining features in later adulthood. *Journal of Personality*. 77(6) 1777-1804.

Olivier, C. (1982) The phenomenological approach for nursing research. *Nurse Researcher*. 31 178-181.

Pallant, J. (2007) *SPSS survival manual*. Open University Press. London

Parry, O et al (1999) Life course data collection qualitative interviewing using the life grid. *Sociological Research Online*. 4(2) 1-13

Patton, M. (2002) *Qualitative research and evaluation methods*. 3rd edition., Sage Publications: Thousand Oaks.

Peele, S. & Grant, M. (1999) *Alcohol, necessary evil or positive good? : Alcohol and pleasure a health perspective*. Philadelphia.

Perkins, H. & Berkowitz, A. (1986) Perceiving the community norms of alcohol use among students: some research implications for campus alcohol education planning. *Substance use and misuse*. 21(9-10) 961-976.

Petticrew, M., & Roberts, H. (2006) *Systematic reviews in the social sciences: A practical guide*. Blackwell. Oxford.

Pilpotim, M., Pearson, N., Petratou, V., Dayanandan, R., Silverman, M. & Marshall, J. (2003) Screening for problem drinking in older people referred to a mental health service: A comparison of CAGE and AUDIT. *Ageing and Mental Health*. 7(3) 171-175

Polit, D., Beck, C. & Hungler, B. (2001) *Essentials of nursing research methods: Appraisal and utilisation*. 5th Edition. Sage: London.

Potter, J., & Wtherall, M. (1987) *Discourse and social psychology*. Sage Publications. London.

Powell, J.E. and McInness, E. (1994) Alcohol use among older hospital patients: Findings from an Australian study. *Drug and Alcohol Review* 13:5-12.

Public Health England (2016) *Health Matters: Harmful drinking and alcohol dependency*. Public Health England. London.

Pruthi, S. (2015) *Diseases and conditions : Alcohol use disorder*. Mayo Clinic. Arizona.

Reeves, A., Basu, S., & McKee, M (2013) Austere or not: UK coalition Government budgets and health inequalities. *Journal of the royal society of medicine*. Vol 106, iss 11. 432-436.

Reid, C., Fiellin, D., & O'Connor, P. (1999) Hazardous and harmful alcohol consumption in primary care. *Arch Intern Med* 159:1681-1689.

Resnick, B., Perry, D., Applebaum, G., Armstrong, I., Cotterman, M., Dillman, S., Elliott, S., Narret, T. & Parrish, J. (2003) The impact of alcohol use in community-dwelling older adults. *Journal of Community Health Nursing*. 20(3) 135-145

Richardson, J., Ong, B., Sim, J. & Corbett, M. (2009) Begin at the beginning: using a life grid for exploring illness experience. *Social Research Update*. 57 1-4.

Richie, J. & Lewis, J. (2003) *Qualitative research practice*. Sage Publications: London.

Riley T & Hawe P (2005). 'Researching practice: the methodological case for narrative enquiry'. *Health Education Research*, Vol.20 no 2, pp. 226-236. OxfordUniversity Press.

Ritchie, J. & Spencer, L. (1994) Qualitative data analysis for applied policy research in A. Bryman and R. G. Burgess [eds.] *Analysing qualitative data* (173-194). Routledge: London.

Roberts, P., & Priest, H. (2006) Reliability and validity in research. *Nursing Standard*. 20 44 41-45.

Robertson, S. (2003) Men managing health. *Men's Health Journal*. 2(4) 111-113.

Robson, C. (2003) *Real World Research*. London. Blackwell publishing.

Roden, J. (2004) Revisiting the health belief model: nurses applying it to young families and their health promotion needs. *Nursing and Health Sciences*. 6 1-10.

Rose, D. (2016) The future of aging research: Should the focus be on not growing old or growing old better? 5, 65-74

Rosenstock, I. (1974) Historical origins of the health belief model. *Health Education and Behaviour*, 2(4) 328-335.

Rosenstock, I. (1966) Why people use health service. *Milbank Memorial Fund Quarterly*. 44 94-129.

Rosin, A. & Glatt, M. (1991). Alcohol excess in the elderly. *Quarterly Journal of Studies on Alcohol*. 32 (1-A) 53-59.

Ross, C., & Sastry, J. (1999) The sense of personal control, social structural causes and emotional consequences in:

Aneshensel, C., & Phelan, J. (1999). *Handbook of the sociology of mental health*. Kluwer academic publishers. New York.

Rotter, J. (1954) *Social learning and clinical psychology*. Prentice Hall.

Royal College of Psychiatrists (2015) *Alcohol and older people*. RCP public education editorial board.

Royal College of Psychiatrists. (2013) *Alcohol in older People*. www.rcpsych.ac.uk. Accessed 21.6.13.

Russell, D., Cutrona, C., Rose, J. & Yurko, K. (1984) Social and emotional loneliness: An examination of Weiss's typology of loneliness. *Journal of Personality and Social Psychology*. 46(6) 1313-1321.

Sarantakos, S. (1998) *Social research*. 2nd edition. Macmillan. London.

Satiene, S. (2015) Learning in later life: The perspective of successful ageing. *Applied Research in Health and Social Sciences: Interface and Interaction*. Vol 12 No 1.

Saunders, J., et al. (1993) Development of The Alcohol Use Disorders Identification test WHO collaborative project on early detection of persons with harmful alcohol consumption. *Addiction*. 88(6) 791-804.

Schutte, K. K., Nichols, K. A., Brennan, P. L., et al (2003) A ten year follow up of older former problem drinkers: risk of relapse and implications of successfully sustained remission. *Journal of Studies on Alcohol*, 64, 367-374.

Sheeran, P., Abraham, C. & Orbel, S. (1999) Psychological correlates of heterosexual Condom Use: A Meta- Analysis. *Psychological*. 125 (1) 90-132.

Silverman, D. (2005) *Doing qualitative research*. 2nd edition. Sage publications: London.

Simmill-Binning, C., Paylor, I. & Wilson, A. (2009) Alcohol and older people drugs. *Alcohol Today*. 9(2) 13-18.

Slota, N. (2003) Methodological considerations in life course theory research. *Disability Studies Quarterly*. Vol 23 No.2 19-29.

Smith, J. & Firth, J. (2011). Qualitative data analysis: The framework approach. *Nurse Researcher*. 18(2) 52-62.

Smith, I., & Foxcroft, D. (2009) *Drinking in the UK: an exploration of trends*. Joseph Rowntree Foundation.

Smith-Bowers, B. (2004) *Quality, choice and security in housing: are gated communities the future for Sheltered housing? Transforming social housing*. The Housing studies Association. Sheffield Hallam University 15-16 April.

Sugarman, L. (1995) *Life span development: concepts, theories and interventions*. Routledge. London.

Tesch, R. (1990) *Qualitative research: Analysis types and software tools*. Falmer Press. Basingstoke.

Timmins, F. & McCabe, C. (2005) How to conduct an effective literature review. *Nursing Standard*. 20(11) 41-47.

Tinker, A. (1997) The Environment of Ageing. *Phil Tran R Soc Land.* 352 1861-1869.

Thompson, N. (1995) *Theory and practice in health and social care.* Open University Press. Milton Keynes.

Towns,C. (2003) A social =norms approach to reducing alcohol consumption among college freshmen. *NASPA journal* 40. 4. 24-37.

Tricehurst, S. (1990) Alcohol and the elderly. *Australian and New Zealand Journal of Psychiatry.* 24(2) 252-260.

Usherwood,A. & Hermansson,G (2008) The 'counselled-deciding- self' in separation and custody: An analysis of narrative. *Journal of divorce and remarriage.* 22. Iss3-4. 221-240.

Valentine,G., Holloway,S., Jayne,M. & Knell,C (2007) *Drinking places: Where people drink and why.* Joseph Rowntree Foundation. York.

Villar, F., Faba, J. & Celdran, M. (2013). Using Older Peoples Life Stories to Teach Developmental Psychology and Ageing: Benefits and Difficulties. *Educational Gerontology.* 39 867-877.

Walter, F., James, T. & Matonowski, M. (1987) The validity of questionnaire reported work history in live respondents. *Journal of Occupational Medicine*. 29(10) 795-800.

Wanless, D. (2004) *Securing good health for the whole population*. HM Treasury: London.

Ward, L., Barnes, M. & Gahagan, B. (2008) *Cheers!?! A project about older people and alcohol*. Age Concern.

Weiss, R. (1973) *Loneliness: the experience of emotional and social isolation*. Cambridge press.

Weinstein, N. (1987) Unrealistic optimism about susceptibility to health problems: Conclusions from a community-wide sample. *Journal of Behavioural Medicine*, 10(5) 481-500.

Welsh Government (2013) *The strategy for older people in Wales 2013-2023*. Welsh Government. Wales.

Werner, P. (2004) Reasoned Action and Planned Behaviour, in S.J., Peterson & T.S. Bredow (eds), *Middle range Theories: Application to Nursing Research*. Lippincott Williams and Wilkins, Philadelphia 125-147.

Weyerer, S., Schaufele, M., Eifflaender- Gorfers, S., Khohler, L., Maier, W., et al (2009) At risk alcohol drinking in primary care patients aged 75 years and older. *International Journal of Geriatric Psychiatry*. 24 1376-1385.

Whitehead,D. & Schneider,Z. (2016) Nursing and Midwifery research: methods and appraisal for evidence-based practice. Elsevier.

Wilson, S., Cunningham-Burley, S., Bancroft, A., Backett-Milburn, K & Masters, H. (2004) *Young people, biographical narratives and the life grid: Young people's accounts of parental substance use*. Joseph Rowntree Foundation.

Wilson, G., Kaner, E., Crosland, A., Ling, J., Smith, K. & Haighton, C. (2013a) We don't go home bow legged: older people's identities and alcohol. *PLoS one*. 8 (8)

Wilson, G., Kaner, E., Ling, J., Crosland, A., McCabe, K. & Haighton, C. (2013b) Exploring older adults' views about alcohol consumption: implications for brief interventions with older heavier drinkers. *Addiction Science and Clinical Practice*. 8(supp 1): a86

Wisker, G. (2001) *The post graduate research handbook: Succeed with your MA, Mphil and PhD*. Palgrave Macmillan: Basingstoke.

World Confederation for Physical Therapy (2017) *Definition of an older person*. www.WCPT.org Accessed 29/05/2017

World Health Organisation (2006) *Working together for health*. WHO. Geneva.

World Health Organisation (2002) *Health Statistics and Information Systems*. WHO. Need correct ref

World Health Organisation. (2000) *The implications for training of embracing a life course approach to health*. The Stationery Office: London.

World Health Organisation (1986) *Ottawa charter for health promotion*. WHO. Geneva.

World Health Organisation (1980) *Problems related to alcohol consumption: Report of a WHO expert committee*. WHO. Geneva.

World Health Organisation (1946) *The constitution of the World Health Organisation*. WHO.

Yin, R. (2003) *Case study research: Design and methods*. Sage. London.

Zimberg S. (1974) Two Types of Problem Dinners: both can be Managed *Geriatrics*. 29 (8) 135.

Zuckerman, M. (1994) *Behavioural expressions and biosocial basis of sensation seeking*. London Cambridge: University Press.

Appendices

Appendix 1 Audit questionnaire



PLEASE SEND BACK COMPLETED
QUESTIONNAIRES IN THE ENVELOPE PROVIDED

Instructions for completing the questionnaire

Please answer all questions as honestly as you can, use the last 12 months as reference.

Please give one answer per question only.

Only put the answers for 1 person.

If you require a second questionnaire please ask the researcher and one will be sent to you.

If you make a mistake cross out the wrong answer fully and then circle the one you meant to choose.

UNITS



Pint of Regular Beer/Lager/Cider



Alcopop or Can of Lager



Glass of Wine (175ml)



Single Measure of Spirits



Bottle of Wine

How often do you have a drink that contains alcohol?	Never	Monthly or less	2-4 times per month	2-3 times per week	4+ times per week
How many standard alcoholic drinks do you have on a typical day when you are drinking?	Never	Monthly or less	2-4 times per month	2-3 times per week	4+ times per week
How often do you have 6 or more standard drinks on one occasion?	Never	Monthly or less	2-4 times per month	2-3 times per week	4+ times per week
How often in the last year have you found you were not able to stop drinking once you had started?	Never	Monthly or less	2-4 times per month	2-3 times per week	4+ times per week
How often in the last year have you failed to do what was expected of you because of drinking?	Never	Monthly or less	2-4 times per month	2-3 times per week	4+ times per week
How often in the last year have you needed an alcoholic drink in the morning to get you going?	Never	Monthly or less	2-4 times per month	2-3 times per week	4+ times per week
How often in the last year have you had a feeling of guilt or regret after drinking?	Never	Monthly or less	2-4 times per month	2-3 times per week	4+ times per week
How often in the last year have you not been able to remember what happened when drinking the night before?	Never	Monthly or less	2-4 times per month	2-3 times per week	4+ times per week
Have you or someone else been injured as a result of your drinking?	no		Yes		yes
Has a relative/ friend/doctor/ health worker been concerned about your drinking or advised you to cut down?	no		yes		yes

Please circle

How old are you?

Appendix 2 Ethics

PhD

Page 1 of 3

Payne, Annette (YHN)

From: David Stanley [david.stanley@northumbria.ac.uk]
Sent: 04 May 2011 17:22
To: Payne, Annette (YHN)
Subject: RE: PhD

Dear Annette

Further to our recent telephone conversation and your explanation of how you propose to conduct the study:

I confirm that in my opinion your University research ethics committee approval is sufficient – always provided that your exclusion criteria explicitly exclude people who lack capacity to give informed consent (and that you will withdraw from the study anyone recruited who develops a lack of capacity to give informed consent) and that the research does not involve NHS staff, premises or medical interventions with patients. Should any of these provisos not be the case you must obtain approval from an NRES REC.

It is a matter for your University REC to determine your appropriateness for working with vulnerable participants generally, and in your ethics application you should make your expertise, resources and research processes clear.

Best wishes for the study
David

*Professor David Stanley PhD AcSS FHEA FRSA
Chair, national Social Care Research Ethics Committee
Chair in Social Care
Northumbria University
School of Health Community & Education Studies
Coach Lane Campus (West)
Newcastle upon Tyne NE7 7XA
United Kingdom
+44 (0) 191 215 6261
david.stanley@northumbria.ac.uk*

From: Payne, Annette (YHN) [mailto:Annette.Payne@yhn.org.uk]
Sent: 03 May 2011 15:16
To: david.stanley
Subject: PhD

David

I wondered if you would have the time to offer me some advice surrounding the ethics process for my PhD. Prof Ann Crosland suggested I contact you to get some advice around whether I needed to go to the health and social care ethics or whether the university boards would suffice.

My PhD title of study is 'To investigate the views and patterns of alcohol consumption of older people living within sheltered accommodation in Newcastle'

I work within health and housing for community health in Newcastle. My study will involve the screening of the sample population for alcohol use and then interviews to theory build using a grounded theory approach. I have access to the sheltered housing team who will be able to highlight any individuals who have dementia,

11/05/2011

Appendix 3 Housing provider letter of support



John P Lee, Chief Executive
Your Homes Newcastle
YHN House
Benton Park Road, Newcastle upon Tyne, NE7 7LX
Tel: 0191 278 8700 Fax: 0191 278 8602
Minicom 0191 278 7727
e-mail john.p.lee@yhn.org.uk
www.yhn.org.uk

Our Ref: NS/(DOTS)/YHN/JL
YHN2011 - 197

This matter is being dealt with by Neil Scott who is available on Tel no. 0191 2788711

28 March 2011

To Whom It May Concern

RE: Annette Payne – The views and patterns of alcohol use for older people aged 55 years and over living in sheltered accommodation in Newcastle.

Annette Payne is a member of our multi-disciplinary health team with a focus on older people. Annette works closely with our sheltered housing and community alarms service. In carrying out her role she has regular access to and contact with residents living in the sheltered housing schemes that we manage. I have discussed Annette's proposals for her research as outlined above and I can confirm that Your Homes Newcastle support her in this. As an organisation we can see the usefulness of the research in our current service and planning services for the future.

In that context we are happy for Annette to make contact with residents in our schemes and will offer support to enable her to reach her target group.

Yours faithfully

A handwritten signature in black ink that reads "Neil Scott".

Neil Scott
Director of Tenancy Services
Your Homes Newcastle



PLEASE KEEP THIS SHEET FOR YOUR
INFORMATION

**Views and patterns of alcohol use in older people
living in sheltered housing in Newcastle upon Tyne**

Information sheet Study 1

You are being invited to take part in a research study. Before you decide whether or not to take part, it is important for you to understand why the research is being done and what it will involve. Please take the time to read the following information carefully and discuss it with other people if you wish. You can speak to the researcher (Annette Payne) from the University of Sunderland if there

is anything that you are unclear about or if you would like more information.

Thank you for reading this.

What is the purpose of the research?

The level of alcohol use by older people living in sheltered housing is not known. Without this information it is hard to put support services in place or to know where to target information. The aim of this research is to try to find out about the views and patterns of alcohol use to help inform these issues.

Why have I been chosen?

You and other people living in sheltered accommodation across Newcastle are being asked if you would be willing to take part in this research to explore views and patterns of alcohol use.

Do I have to take part?

It is completely up to you to decide whether or not to take part in the study. Even if you decide to take part you are still free to drop out at any time without giving a reason. A decision to stop or not to take part will not affect you, your relationship with your housing provider or your rights as a tenant in any way.

What does taking part involve?

You will be required to complete the enclosed questionnaire and return it to the researcher in the prepaid envelope. You are asked to answer the questions with the previous 12 months in mind. A drink is classed as $\frac{1}{2}$ pint of beer, cider or lager, or 1 small glass of wine.

Will my taking part in this study be kept confidential?

After the questionnaires have been completed and returned they will be entered into a database by the

researcher which only be accessible by her and her research supervisors. They will not be shared with anyone else. They will be stored securely and destroyed after the research is complete. There is no way of identifying you from the questionnaire.

What will happen to the results of the research?

The information you and others give will be analysed by the researcher to identify the range of views and experiences of all those taking part. A large report will be produced as part of a Doctoral degree project (PhD) which will present these views to the University of Sunderland exam board; it will then be made publicly available. Research papers and conference presentations will also be produced. Participants will receive a summary of the findings after the final report has been circulated.

Who is organising the research?

The research is being carried out by Annette Payne, a PhD student from the University of Sunderland.

What should I do next?

If you do not want to take part in the study you do not need to do anything.

If you are interested in taking part then please complete and return the enclosed questionnaire in the envelope provided. You do not need a stamp.

Contact information for further information

If you would like to speak to someone about the study or if you need any further information then please contact

Annette Payne (PhD student)

Department of Pharmacy, Health & Wellbeing

Faculty of Applied Sciences

University of Sunderland

Sunderland

SR1 3SD

Tel: 07855827985

Email: Annette.payne@sunderland.ac.uk

Or

Dr Jonathan Ling

Department of Pharmacy, Health & Wellbeing

Faculty of Applied Sciences

University of Sunderland

Sunderland

SR1 3SD

Email: Jonathan.ling@sunderland.ac.uk



PLEASE KEEP THIS SHEET FOR YOUR
INFORMATION

**Views and patterns of alcohol use in older people
living in sheltered housing in Newcastle upon Tyne**

Information sheet study 2

You are being invited to take part in a research study. Before you decided whether or not to take part, it is important for you to understand why the research is being done and what it will involve. Please take the time to read the following information carefully and discuss it with other people if you wish. You can speak to the researcher, Annette Payne, from the University of Sunderland if there

is anything that you are unclear about or if you would like more information.

Thank you for reading this

What is the purpose of the research?

The levels of alcohol use by older people living in sheltered housing are not known. Without this information it is hard to put support services in place or to know where to target information. The aim of this research is to try to find out about the views and patterns of alcohol use to help inform these issues.

Why have I been chosen?

You and other people living in sheltered accommodation across Newcastle are being asked if you would be willing to take part in this research to explore views and patterns of alcohol use.

Do I have to take part?

It is completely up to you to decide whether or not to take part in this study. Even if you decided to take part you are still free to drop out at any time without giving a reason. A decision to stop or not to take part will not affect you, your relationship with your housing provider or your rights as a tenant in any way.

What does taking part involve?

You will be asked to attend an interview with the researcher. This will be at a time and place to suit you and the researcher. The interview will last about 1 hour and be audio recorded (with your permission) to help the researcher to remember what you have said. You will be asked about your drinking behaviour, your views on drinking and some of your life history.

Will my taking part in this study be kept confidential?

After the interviews have been completed, the recordings will be typed up and any information that could identify people will be removed. The interviews will be deleted after they have been typed up. No one other than the researcher, her 3 supervisors will be able to listen to the recordings or read the interview transcripts. The transcripts and other documents containing your details will be stored securely in a locked cabinet and then destroyed six years after the end of the study.

What will happen to the results of the research?

The information you give will be analysed by the researcher to identify the range of views and experiences of all those taking part. A large report will be produced as part of a Doctoral degree project (PhD) which will present these views to the University of Sunderland exam board; it will then be made publicly available via the university library. Research papers and conference presentations will

also be produced. Participants will receive a summary of the findings after the final report has been circulated.

Who is organising the research?

The research is being carried out by Annette Payne, a PhD student, from the University of Sunderland.

What should I do next?

If you do not want to take part in the study then you do not need to do anything.

If you are interested in taking part, please complete and return the consent form with your completed questionnaire so that the researcher can contact you to arrange a date, time and location for the interview.

Contact information for further information

If you would like to speak to someone about the study or if you need any further information then please contact

Annette Payne (PhD student)

Department of Pharmacy, Health & Wellbeing

Faculty of Applied Sciences

University of Sunderland

Sunderland

SR1 3SD

Tel: 07855827985

Email: Annette.payne@sunderland.ac.uk

Or

Department of Pharmacy, Health & Wellbeing

Faculty of Applied Sciences

University of Sunderland

Sunderland

SR1 3SD

Tel: Email: Jonathan.ling@sunderland.ac.uk



**University of
Sunderland**

PLEASE RETURN WITH COMPLETED
QUESTIONNAIRE

Consent Form Study 2

**Project Title: Views and patterns of alcohol use in
older people living in sheltered housing in Newcastle
upon Tyne**

Name and Address of Participant (please print)

.....

.....

.....

.....

.....

Please tick

- I have read the information sheet given to me and have had time to think about the research project.

- I have had the chance to ask any questions about the research project.

- I understand that the information I give will be used to help provide information about alcohol use and older people.

- I consent to any interviews being tape recorded.

- I consent to the use of information I give (no identifiable information) being used as part of the PhD research, associated publications and future research.

I understand I can stop being part of the research project at any time without having to give a reason and without my accommodation being affected.

I agree to take part in the research project.

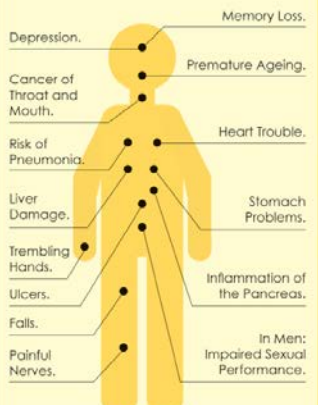
Signature & Date

.....

.....

Appendix 7 Older persons' alcohol leaflet

The effects of alcohol on the body.



Depression.

Memory Loss.

Premature Ageing.

Cancer of Throat and Mouth.

Heart Trouble.

Risk of Pneumonia.

Liver Damage.

Stomach Problems.

Trembling Hands.

Inflammation of the Pancreas.

Ulcers.





Falls.

Painful Nerves.

In Men: Impaired Sexual Performance.


Alcohol related hospital admissions for people over 65 years old are on the increase...

The Royal College of Psychiatrists recommend that people over the age of 65 should not drink more than 2 units of alcohol on any one day

-  Large wine glass
13% ABV - **3.3 units**
-  Small fortified wine glass (e.g. sherry)
17.5% ABV - **1.0 units**
-  Single measure of spirits
40% ABV - **1.4 units**
-  A pint of premium beer
5% ABV - **2.8 units**

It is recommended that you should have at least 2 alcohol free days a week


For tips and advice on how to reduce your drinking log onto:
www.nhs.uk/change4life



Alcohol and medication don't mix

If you are on medication, be careful when having a drink. It can cause:

- balance problems
- mobility problems
- falls
- accidents



If you are concerned about how your medication interacts with alcohol please ask your GP or practice nurse.

The answer isn't at the bottom of the glass...



Whether you are drinking to socialise, cope with difficult times or just to relax you may not realise how much you are drinking and the damage it could cause. A small change can make a lasting difference to your health.



Are you concerned with how much you, a relative or a friend is drinking?

If you are concerned then contact:

Lifeline:
Alcohol Treatment Service Newcastle
Tel: 0191 2615610

Parents / Carers of drug and alcohol misusers can receive advice and information from Newcastle P.R.O.P.S.
Tel: 0191 226 3440
www.newcastleprops.org.uk

Drinkline a free, confidential helpline for people who are concerned about their drinking, or someone else's.
Tel: 0300 123 1110

Alcoholics Anonymous for support and to hear how others have recovered.
Tel: 0191 5244400
www.alcoholics-anonymous.org.uk

Designed & Produced by **Ice*** www.icecreates.com

Alcohol and Older People



As we grow older it's harder for our body to deal with the effects of alcohol.



This leaflet provides information and advice about the risks of alcohol for older people.

Appendix 8

Example from code book

Male -1

Female 2

Not recorded -3

Age as a number or 0

How often do you have a drink that contains alcohol?

Never -1

Monthly -2

2-4 times a month – 3

2-3 times a week – 4

4+ a week – 5

No answer - 6

Appendix 9 Interview guide

Introductions

Complete consent

Complete survey

Refer to survey around level of drinking

Has this always been the same?

Family history and behaviours parents, husband wife children

Life grid to prompt

Work life differences for men to women did the war make any difference