DRUG & ALCOHOL FINDINGS Review

analysis

This entry is our analysis of a review or synthesis of research findings considered particularly relevant to improving outcomes from drug or alcohol interventions in the UK. The original review was not published by Findings; click Title to order a copy. Free reprints may be available from the authors – click prepared e-mail. Links to other documents. Hover over for notes. Click to highlight passage referred to. Unfold extra text The Summary conveys the findings and views expressed in the review. Below is a commentary from Drug and Alcohol Findings.

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▶ Interventions to reduce the negative effects of alcohol consumption in older adults: a systematic review.

Armstrong-Moore R., Haighton C., Davinson N. et al.

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Unable to obtain a copy by clicking title? Try asking the author for a reprint by adapting this prepared e-mail or by writing to Dr Armstrong-Moore at Roxanne.armstrong@sunderland.ac.uk.

The first review to focus on alcohol interventions for older people found some evidence that psychosocial interventions such as counselling and brief advice were effective, but the studies lacked sufficient detail to determine which elements of the interventions might be having an effect.

SUMMARY Older people are disproportionately affected by life changes that can impact their level of alcohol consumption, such as bereavement, social isolation, loneliness, and being out of employment (eg, through retirement). Compared with younger people, they are also more susceptible to the adverse effects of alcohol, and being more likely to take prescription medications, are also more likely to experience side effects or to find their medications do not work as intended due to interactions with their drinking. By 2050, it is estimated that a fifth of the world's population will be over the age of 60, with a significant proportion showing a "pattern or level of drinking which places them at harm".

The featured review aimed to understand the effectiveness of interventions targeted at older people in reducing drinking and alcohol-related harm. Seven studies were included – six conducted in the United States and one in Denmark, all (where known) in primary care centres. Intervention methods included: brief interventions; motivational enhancement therapy and brief motivational interventions; brief advice; health and alcohol risk education; personalised risk reports; and telephone counselling.

All but one of the seven interventions were carried out face-to-face, and five followed these meetings with telephone calls. Two were carried out solely by physicians, one by a combination of physician and health educators, and four used a combination of trained research assistants/interventionists, care providers, health educators, and postgraduate students.

Participants in six of the interventions were identified before the studies took part as heavy, hazardous, or problem drinkers; the remaining intervention recruiting participants who had consumed more than one alcoholic drink in the last three months.

Key points

From summary and commentary

Older people are disproportionately affected by life changes that can impact their level of alcohol consumption, and are more susceptible to alcohol-related harm.

This review was the first to specifically examine the effectiveness of alcohol interventions for older people. While every intervention was associated with improvements in at least one area of alcohol consumption or frequency of consumption, not all these improvements reached the level of statistical significance.

The information provided in the individual studies was also insufficient to understand which specific elements of the interventions were effective.

Participants assigned to the interventions were compared with participants in control groups, who were described as receiving anything from no intervention, to care as usual, to booklets on drinking and healthy behaviours. There was no apparent restriction or discouragement from talking about alcohol in the control groups.

The main outcome measure in the review was reduction in reported alcohol consumption. Other outcomes included general health, risky drinking, and knowledge about alcohol.

Main findings

On at least one measure all the interventions were followed by improvements over the next 12 months, including lower drinking frequency and consumption, reduced drinking over a seven-day period, lower rates of heavy episodic drinking, fewer visits to physicians and emergency departments, lower frequency of 'binge drinking' episodes, lower frequency of excessive drinking, and reduced harmful and hazardous drinking. However, not all changes were statistically significant when the results of the interventions were compared with control groups, meaning the improvements may not have been due to the intervention.

Study one involved a relatively small sample (45) of hazardous drinkers over the age of 66. Significant reductions were observed in the frequency of drinking measures across all groups regardless of the intervention. However, there was no difference between the brief interventions (motivational enhancement therapy and brief advice) and the control group (standard care). [Over the course of a year, participants in each of the groups increased the number of days of reported abstinence, decreased the number of drinks per day, and reduced the number of drinking days per month].

Study two included 772 participants over the age of 50 who were heavy drinkers. The study found that alcohol consumption was reduced at both six and 12 months. However, there were no significant differences between those who had the brief motivational intervention and those in the control group who given two leaflets about alcohol.

Study three piloted the efficacy of personalised mailed feedback and educational booklets in reducing at-risk drinking in 86 adults aged 50 and over. At three months there were no significant differences in drinks per week between the intervention and the no-intervention control group.

Study four investigated 1186 participants over the age of 60 who were at-risk drinkers, 1049 of whom completed the full 12 months of the Project SHARE (Senior Health and Alcohol Risk Education) intervention. The intervention was effective at six months and 12 months, significantly reducing alcohol consumption, heavy episodic drinking, and reducing patients' visits to physicians and emergency departments compared to the usual-care control group.

Study five included 158 participants over the age of 65 who were problem drinkers. Compared with the control group given a general health booklet, participants who received brief physician advice significantly reduced their episodes of binge drinking, drinking over a seven-day period, and frequency of excessive drinking (over 30 drinks a week for men and 13 for women).

Study six investigated the effects of an intervention with multiple components (including a personalised report, booklet on alcohol and ageing, diary to log levels of drinking, advice, and telephone counselling) versus a booklet on healthy behaviours, with 631 participants over the age of 55. At three months the intervention reduced the proportion of at-risk drinkers, participants were more likely to report having fewer drinks in the last seven days, and had a lower risk score relative to the booklet-only control group. However, at 12 months only the difference in the reduction in the number of drinks consumed over the past seven days remained significantly significant.

Study seven was carried out with 665 participants over the age of 55 at risk of alcohol-related harm. There were two intervention groups (one where patients received a report on their drinking and its associated risks, and another where both physician and patient received the report) and one control group (usual care). Twelve months later both interventions were more likely than usual care to have increased the proportion of patients whose drinking was relatively low risk, though only when both physician and patient were involved in the intervention was there a greater reduction in the average quantity of alcohol drunk per week.

The authors' conclusions

While another review has addressed recent advances in substance use treatments for older people and the effectiveness of interventions for substance use problems as a whole, the featured review was the first to focus specifically on the effect of interventions on drinking later in life.

The interventions carried out in primary care centres showed varying levels of success. Every intervention was associated with improvements in at least one area of alcohol consumption or frequency of consumption, but not always to a statistically significant level.

Effective psychosocial interventions included counselling and advice on risky behaviours, education, and personalised risk reports. However, the lack of detail in studies prevented the reviewers from understanding which elements of the interventions were effective.

FINDINGS COMMENTARY UK statistics on drinking behaviour, alcohol-related hospital admissions, and alcohol-related deaths show that older people drink less and are less likely to exceed the recommended drink limits than younger adults but are more likely to experience high levels of alcohol-related harm, and between the ages of 55 and 74 have the highest rates of alcohol-related deaths. Despite a clear rationale for investigating alcohol interventions aimed at older people, the dearth of studies in this area constrained the featured review and how much it could discover about what constitutes an effective intervention.

Several years ago, the VINTAGE project tried to fill the gap in understanding around older people and harmful drinking, by collecting and analysing best practice in Europe. In 2012, the published results indicated that:
• new programmes were needed, and would ideally cater to the diversity of factors affecting older people and their drinking, including differences along gender lines;
• screening and intervention techniques were increasingly being researched, but not being integrated to the same extent into practice;
• there was an overall lack of evidence and initiatives to support older people at the community level;
• public awareness about the effects of drinking among people who are older was growing, although a critical mass demanding higher levels of awareness and public health intervention had yet to be reached.

One factor associated with the still-limited evidence base is the relative neglect of older people in alcohol awareness campaigns and policies compared with young and 'under-age' people. Indeed, while young people and young adults were mentioned 31 times in the UK government's 2012 alcohol strategy (summarised in the Effectiveness Bank), there were zero mentions of older people.

Older people are also at a disadvantage when it comes to treatment and support. A report funded by Alcohol Research UK examined the accessibility and suitability of residential alcohol treatment for older adults, finding that three out of four residential facilities in England were excluding older adults on the basis of arbitrary age limits – presenting a major barrier to older people securing a place in residential treatment, and conflicting with the message from the National Treatment Agency in 2012 that residential treatment is a vital component of the treatment system to which "anyone who needs it should have easy access". While the study could not find out why centres were imposing age limits, conversations with service managers suggested it could be due to an assumption that the care needs of an older adult would be higher and therefore not be able to be met in the existing treatment setting.

Given their high level of contact with older people, social workers are considered ideally placed to identify and intervene with drinking problems in this population. However, studies from around the world have shown that alcohol problems in older people frequently go undetected or ignored. Informed by the perspectives of older people receiving alcohol treatment and practitioners who specialise in working with older people, a UK study highlighted the key issues for social workers, which have relevance beyond the profession:

1. The stigma attached to older people's drinking problems is generally greater than that for younger people, and can motivate older people to conceal their drinking. Practitioners should consider embedding drinking questions in the context of other health behaviours, and avoid the use of stigmatising words such as 'alcoholic'.
2. Social workers should be alert to signs of abuse in older people where they or those who care for them have a drinking problem, and be aware that signs of 'elder abuse' such as bruising, agitation, withdrawal, depression, and malnourishment can be mistakenly attributed to an older person's alcohol problem and vice versa.
3. There is a need to challenge ageist attitudes and myths relating to older people's alcohol consumption, including the idea that an intervention is not needed because the patient is too old, may not have long to live, or that drinking is one of their remaining pleasures in life.
4. Social care professionals should consider the balance of 'risks' and 'rights' in older people with alcohol problems, which may come into play, for example, if an older person needs

help with purchasing alcohol.

The Tilda Goldberg Centre for Social Work and Social Care, which is home to the Substance Misuse and Ageing Research Team, has produced a pocket guide of essential information for social workers about working with older people who drink.

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