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ARTICLE

Coping with COVID-19 lockdown: a qualitative study of older adults in alcohol treatment

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Abstract

The COVID-19 global pandemic had a major impact on older people's mental health and resulted in changes in alcohol use, with more older adults increasing than decreasing consumption levels among the general population. So far, no studies have focused on older people who were already experiencing problem alcohol use. This qualitative research is the first to provide a nuanced understanding of changes to drinking patterns among older adults engaged in alcohol treatment during the COVID-19 pandemic, and the implications of these for practice. We conducted 30 semi-structured interviews with people in alcohol treatment aged 55+ living in urban and rural areas across the UK. Data were analysed using thematic analysis. We found that changes in alcohol use varied depending on the social, economic and health impacts of the pandemic on older adults. Boredom, lack of adequate medical or emotional support, and key life changes experienced during the pandemic (such as bereavement or retirement) increased the risk of increased drinking. Moreover, some people in longer-term alcohol treatment were struggling to maintain abstinence due to lack of face-to-face peer support. For others, decreased drinking levels were a side-effect of lockdown policies and restrictions, such as alcohol-related hospitalisations, closure of social spaces or inability to source alcohol; these also supported those who decided to cut down on drinking shortly before the pandemic. Generally, older adults who developed home-based interests and self-care practices managed lockdown best, maintaining abstinence or lower risk drinking levels. Based on these results, we argue that multilevel interventions aimed at strengthening resilience are required to reduce drinking or maintain abstinence among older adults. Such interventions should address three domains: individual (coping strategies and mindset), social (support networks), and structural (access to resources). In preparation for supporting older alcohol users through prospective future pandemics, building digital literacy and inclusion are essential.

Keywords: older adults; alcohol; alcohol treatment; coping strategies; COVID-19; pandemic; qualitative; United Kingdom

Introduction

The COVID-19 pandemic had implications for people's health, mental health and social functioning. The elderly, and people with pre-existing medical, psychiatric or substance use problems were believed to be at increased risk for adverse psychosocial outcomes, such as depression, anxiety, psychosomatic preoccupations, insomnia, increased substance use, and domestic violence (Pfefferbaum and North, 2020).

The COVID-19 pandemic, and the resulting 'lockdown' (stay-at-home orders) and social distancing measures enacted to try and contain the spread of the virus led to increased social isolation, loneliness and depression among older people (Centre for Ageing Better, 2020; Krendl and Perry, 2020; Wu, 2020). Older adults, already vulnerable to experiencing isolation (Nicholson, 2012; Satre *et al.*, 2020), appeared to be at greater risk of experiencing negative effects from social distancing and lockdown measures. This had the potential to lead to poorer mental health, such as increased anxiety, depression and substance use (Satre *et al.*, 2020). This was especially true for those living alone; they were at greater risk of poor mental health (Centre for Ageing Better, 2020). These issues may have been further exacerbated by restrained access to healthcare during the pandemic (Centre for Ageing Better, 2020; Satre *et al.*, 2020).

It is estimated that among the general population in the United Kingdom (henceforth UK), between a fifth and a third of people increased their use of alcohol in response to the first national lockdown (Institute of Alcohol Studies, 2020), and the rate of risky drinking increased by 13 per cent (Jackson *et al.*, 2020). But there was also evidence that a small proportion of people reduced their drinking. A survey of 2,000 people in the UK found that 21 per cent increased their use of alcohol, but nine per cent were drinking less (Alcohol Change UK, 2020). There was some evidence to suggest that stress and psychological distress associated with COVID-19 may have resulted in increased use of alcohol (Rodriguez *et al.*, 2020; Roberts *et al.*, 2021).

Research suggested there were similar changes in the use of alcohol among older adults during the pandemic. A survey of the general population of older people aged 50–70 years in England found 32 per cent had increased their drinking, while 22 per cent had reduced their use of alcohol (Centre for Ageing Better, 2020). The survey also highlighted that anxiety and lack of work resulted in increased drinking, whereas the closure of pubs and other social spaces related to drinking resulted in decreased drinking (Centre for Ageing Better, 2020). Concern was raised that older adults may be at increased risk of adverse effects of drinking due to age-related physiological changes, comorbid health conditions, and use of prescribed medications (Heuberger, 2009). If, as data suggested, alcohol use increased among some older adults in response to the pandemic (Centre for Ageing Better, 2020), it is important we understand the reasons for this. It is equally important to understand why some people decreased their drinking during the pandemic. Understanding how and why patterns of alcohol use changed during lockdown may help in designing adequate interventions and planning for alcohol treatment services during pandemics, disasters and national emergencies.

Our particular focus on older people in alcohol treatment was informed by some seminal studies on treatment outcomes and the need to address this gap in

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knowledge. Satre *et al.* (2012) found that negative life transitions (such as death, unemployment, poor health and poor social relationships) – many of these typical of older age – were associated with poorer alcohol and drug treatment outcomes. Sobell *et al.* (1996) found that while most people (across all age groups) recovered from problem alcohol use without formal help, those in treatment reported higher levels of drinking and alcohol-related problems. In their 2020 editorial, Satre *et al.* (2020) called for research on older adults who were drinking during COVID-19, pointing to the lack of understanding of how social isolation and mental health conditions may have increased substance use among this group. Considering recent studies of alcohol interventions for older adults which show that greater levels of social capital (thinking positively about life and good social relationships) are associated with reduced alcohol risks among older drinkers (Adnum *et al.*, 2022), and other studies pointing to particular barriers for older adults in accessing alcohol support during COVID-19 (Seddon *et al.*, 2021), these concerns appear well-founded.

While there is some research on the impact of COVID-19 on alcohol consumption among older people in the UK (Centre for Ageing Better, 2020), there appear to be two gaps in the evidence base. Firstly, quantitative surveys are unable to provide insights into the underlying explanatory factors behind changes in alcohol use among older adults. Secondly, these surveys focus on the general population of older people and not those already experiencing problem alcohol use.

This qualitative research is the first to examine the reasons for change in alcohol use among older adults engaged in alcohol treatment during the COVID-19 pandemic. In doing so, we compared older adults who were already in alcohol treatment pre-pandemic and those who only joined an alcohol service during the pandemic.

Methods

The data presented in this paper is based on a qualitative study of the experiences of older alcohol service users during the pandemic. As set out in the introduction, the majority of studies into alcohol use during the pandemic were based on survey data. While these data provide us with information on general trends in alcohol use, they do not allow for an in-depth analysis of the reasons behind and nuanced patterns of these changes. Moreover, quantitative studies of alcohol use among older people carried out during the pandemic focused on the general population and not on persons with identified alcohol problems. This qualitative study aimed to fill this gap in knowledge. Hence is it based on older people's lived experiences of alcohol use and alcohol service provision during the pandemic.

Primarily, our study aimed at exploring experiences of alcohol service provision and alcohol treatment during the pandemic from the perspective of service providers and older service users. An analysis of these has been presented in an earlier paper (Seddon *et al.*, 2020; Seddon *et al.*, 2021). However, the rich accounts of the older people we interviewed, and the varying patterns of alcohol use we observed, inspired us to write this paper. Drawing out such depth and complexity of data would not have been possible through carrying out a survey.

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Study design and participant recruitment

Study participants were recruited via alcohol and drug support services. Through our professional networks, we identified and approached seven drug and alcohol treatment services across the UK providing support to people aged 55+. The seven services covered both urban and rural sites across England, Wales, Scotland and Northern Ireland. All services provided a range of psycho-social interventions, with a focus on harm reduction. One service was a specialised older adults' alcohol treatment service. We aimed to recruit up to 30 older adults, aged 55+, who were using alcohol treatment services during the pandemic. Participants were recruited by service staff from their client lists; participants were selected on the basis of gender and locality (*i.e.* urban, suburban, rural). Recruitment of participants via service staff is common in health research (Patterson *et al.*, 2011).

Service recipients who expressed an interest in taking part in the study were sent a study information sheet and consent form (by post) for their consideration. If they confirmed interest in the study their contact details (first name and phone number) were passed on to a member of the research team who contacted them, explained the purpose of the study and obtained verbal consent. Final (formal) consent for taking part in the study was obtained verbally prior to starting the interview and was audio-recorded.

Interviews and data analysis

Individual semi-structured interviews were conducted with participants over the phone. Interviews lasted one hour on average and were audio-recorded with the participants' consent. The aim of the overall study was to explore lived experiences of alcohol treatment provision and alcohol consumption during COVID-19. Apart from questions focusing on alcohol support, interviews covered participants' physical health, mental health and various impacts of the pandemic, including alcohol use. Interviews took place between July and September 2020.

All interviews were transcribed verbatim and were analysed using NVivo (version 12). Thematic analysis was used to analyse the data following the principles of Braun and Clarke (2006). Thematic analysis is a method for identifying, analysing and reporting patterns (themes) within data (Braun and Clarke, 2006). In this study, we applied thematic analysis from a realist standpoint, reporting the lived experiences, meanings attributed to these, and the reality of the study participants.

We carried out thematic analysis both deductively and inductively, following pre-defined themes shaped by the interview questions but also drawing out themes which we had not enquired about but which our interviewees saw as important to their experiences and mentioned spontaneously. We first coded the qualitative material deductively, applying pre-determined codes to the data. These were shaped by the four key themes discussed in the individual interviews:

(1) personal circumstances – family situation, support networks, living arrangements, access to and use of technology;
(2) alcohol use and any changes to alcohol use during the pandemic;
(3) impact of lockdown on other aspects of life – health, mental health, finances, relationships; and,

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(4) use of alcohol treatment services – engagement with services prior to and during the pandemic, opinions on service provision.

Within each of these themes we created a number of detailed sub-codes, some deductively (again, following the more detailed interview questions) and others inductively – to include matters spontaneously and repeatedly mentioned by our participants. The key 'bottom-up' themes were: own attitudes towards and perceptions of COVID-19, observations and opinions on other people's behaviours during the pandemic, history of drinking and treatment, other personal stories, such as family relations over time or relationship history.

Following this thematic analysis, we also conducted comparative analysis within our sample focusing on individual drinking patterns throughout lockdown, and the reasons behind any changes in these. In doing so, we applied the principle of constant comparison to ensure the identified themes are consistent and supported by multiple interviews (Glaser and Strauss, 1967; Strauss and Corbin, 1998). We checked for similarities and differences between the study participants and grouped participants into three general categories according to self-reported changes in their alcohol use during the pandemic. Based on retrospective estimates of alcohol consumption pre- and during the first phase of the pandemic (between March 2020 and time of interview – between July and September 2020), we differentiated three groups among our study participants:

(1) those who overall increased their use of alcohol;
(2) those who overall decreased their use of alcohol;
(3) those who maintained lower risk drinking levels or abstinence.

Notably, our sample did not include any persons who continued drinking at the same high-risk levels without any change (either increase or decrease). We carried out a detailed analysis of these nuances and the reasons behind increasing, decreasing, or maintaining abstinence or low risk drinking levels as well as patterns of change in alcohol use during the pandemic. The results of this comparison are presented in this paper.

In order to protect study participants' anonymity, all given names in the quotes presented in this paper are pseudonyms.

Measures

Alcohol use was assessed by using the Alcohol Use Disorders Identification Test-Consumption (AUDIT-C). The AUDIT-C is a three-item screening tool, scored on a scale of 0–12. A score of ≥3 for women and ≥4 for men indicates hazardous use of alcohol (Bush *et al.*, 1998; Bradley *et al.*, 2007; Reinert and Allen, 2007). The measure has been validated for use among older adults (Gómez *et al.*, 2006; Aalto *et al.*, 2011). Questions were framed in the context of drinking behaviour since lockdown began; we explored self-reported drinking levels pre-pandemic and during the first phase of the pandemic, from March to July-September 2020. Importantly, drinking patters during this time were not static. While AUDIT-C was used to describe the study sample, comparisons of alcohol

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consumption pre- and during the first phase of the COVID-19 pandemic were based on retrospective self-reports provided at interview. Fluctuations in drinking patterns during this period are thus discussed through an in-depth analysis of the qualitative findings.

Participation in the study was completely voluntary, and participants could withdraw from the study within 4 weeks of providing the interview. Study participants were recruited using purposive sampling via gatekeepers. They were initially contacted by alcohol service staff with information on the study; if they expressed an interest in participating, their contact details were passed on to the researchers. Participants provided informed consent to being contacted by the research team and next to participate in the interview. All participants received a study information sheet and provided verbal consent for taking part in the research and for recording prior to the interview. All interviews were carried out over the phone.

All information provided was confidential to the research team. To protect participants' anonymity and confidentiality, pseudonyms were used instead of names in all written materials from the study. Interview transcripts had been fully anonymised: references to any personal data by which participants could be identified, such as place names, workplace, or names of family members, had been removed. Transcripts were stored on password-protected devices accessible to the research team only.

Results

Participants

Our study sample consisted of 30 people aged 55+ from across the four countries of the UK who had used alcohol services. Twenty participants were male and ten were female. The mean age of participants was 66 years (SD: 6.14, range: 57–80 years). Nineteen participants lived in a rural setting and 11 lived in an urban setting (town or city). Our sample varied considerably in terms of interviewees' individual circumstances, such as family circumstances (single, married, widowed), living conditions (living alone or with others, in a flat or house, access to garden or green spaces or not), financial status (lower or higher income level, assets), and general health levels (varying from good general health to having multiple health conditions). Financial status and health status were not measured quantitively but based on participants' self-reports: descriptions of living conditions and general health. Eleven of our interviewees were shielding during the pandemic. In most cases, this was advised by medical professionals in view of underlying health conditions. For others, who were very much fearful of contracting the virus, it was a matter of personal choice in 'taking precautions.'

Our sample also differed greatly in terms of history of alcohol use: some participants had been using an alcohol service for several years while others only joined the service during the pandemic (this was the case for seven participants).

The mean AUDIT-C score was 4.4 (SD: 4.25, range 0–12). Twelve participants were abstinent throughout lockdown and had an AUDIT-C score of 0. Of the remaining participants, one (male) was drinking at a very low level with an AUDIT-C score of 3, and seventeen were drinking at harmful levels with an AUDIT-C score between 4 and 12, including five people drinking very heavily with AUDIT-C scores between 10 and 12.

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Findings: COVID-19 and alcohol use

In this section we will analyse the factors that contributed to a change in drinking levels (either an increase or a decrease) or maintaining abstinence or lower risk drinking over lockdown among our interviewees. In doing so, we shall look at individual experiences of older alcohol service users and draw out the differences between those in longer-term alcohol treatment and those who only became abstinent or cut down on drinking shortly before or during the pandemic (Table 1).

Reasons behind increased drinking

Difficulties in accessing adequate healthcare support were common. In some cases, lack of adequate medical (and emotional) support was seen as the cause of increased alcohol consumption during lockdown. Helen, quoted below, could not get support from her General Practitioner (family doctor) for her ongoing sleeping issues. She felt it was mainly her problems with sleep that triggered her to have a drink after many years of abstinence:

> I found it quite difficult trying to explain to a doctor what I was feeling (…). I wasn't sleeping well at all and she said, oh, everybody's got that problem and we at the practice don't give out sleeping tablets. That was quite a hard one (…). Just… just… we don't give… we don't give out sleeping tablets, you know (…). I think, that was the worst time when I did start drinking… because it was… it was horrendous. It was… you know, you're wakened all the time… That was a big reason why I started drinking during lockdown. (Helen, 64, urban area)

Table 1. Factors impacting on drinking patterns of older alcohol service users during the COVID-19 lockdown

Increased drinking	Decreased drinking	Maintaining abstinence or lower risk drinking
Risk factors: Lack of adequate medical and/or emotional support Key life changes or crisis situations (*e.g.* losing employment, becoming homeless, retirement, bereavement) Boredom	By choice or an unexpected circumstantial side-effect: Spurred by alcohol-related hospitalisation or health problems and subsequent alcohol support Side-effect of changing place or residence and developing new routines (*e.g.* caravan, care home) Side-effect of not being able to go out shopping (lower than usual alcohol supply)	Protective factors for the newly abstinent lockdown restrictions (*e.g.* no opportunities for social drinking, less work pressure) Protective factors for all participants: Developing coping mechanisms to manage mental health (*e.g.* new hobbies to do at home, staying in touch with family and friends *via* phone calls) and self-regulate alcohol use (*e.g.* drink diary, managing cravings by drinking other liquids, finding new distractions) Receiving support from alcohol services

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For some of our interviewees, key changes in life circumstances experienced shortly before or during the pandemic, such as unemployment, retirement, or a loved one's illness or death, resulted in increased drinking. Ian, who lost his job shortly before the pandemic and could not find other work, was experiencing financial hardship which subsequently led to homelessness. While he had always been a 'social drinker', this life crisis resulted in drinking in excess:

> Well, it's [COVID] affected me quite a lot. Job wise, my mental health, quite a lot of depression. I've been drinking too much (…). It built up to a bottle of spirits a day. (Ian, 64, rural area)

For some other interviewees, deterioration in a loved one's condition or losing a loved one also led to drinking more. For instance, Mary, who had retired only a couple months before the pandemic, found this time coincided with a serious decline in her sister's health as well as their lodger leaving, which entailed financial issues. She began to struggle with emotional problems and alcohol use, and saw these issues as exacerbated by lockdown:

> This [deterioration in my sister's health and the lodger leaving] has caused me a fair bit of stress, obviously, and I think that that was why my drinking increased (…). I was drinking quite a lot habitually in the evenings [prior to the pandemic] and it's still habitual in the evenings but it's just the quantity that has increased over the last, well, since March. [Earlier] I had some days normally when I wouldn't drink during the day, [and] there'd be two or three days that I wouldn't drink. Then with COVID and not going out, I didn't have reasons not to drink so they went out the window and I was drinking every day, and I was up to half a bottle of spirits a day in the evening. (Mary, 70, rural area)

A few of our interviewees were dealing with bereavement during the pandemic. While losing a loved one is always a difficult experience and a frequent cause of harmful drinking in older age (Holley-Moore and Beach, 2016), a major difference was that under lockdown conditions the recently widowed could not access their usual support structures. John, who had lost his wife shortly before lockdown, was finding it too much to cope with her death and the restrictions at the same time. As a result, he started drinking excessively:

> [My wife] dying on 26th February, her funeral, I couldn't get her funeral till 18th March and then after the funeral, I just started drinking and the lockdown, no-one could come and visit me at the time and I couldn't go out and er, the lockdown… I suppose it was grieving just as much as the lockdown but the two combined, it was a very, very bad period for me. (John, 70, town)

Going through bereavement during lockdown was particularly challenging and led a few of our interviewees to start drinking heavily. They found the need to stay at home, along not being able to meet family and friends, impossible to cope with.

Indeed, the need to stay at home and not mix with others was challenging for the majority of our interviewees, in particular those living alone. Many people were

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struggling with boredom. In a number of cases, having nothing to do and not being able to pursue their usual distractions led people to start drinking or drink more than usual. Several of our interviewees found they did not have adequate coping mechanisms to tap into under lockdown restrictions:

> Every day seems a bit the same and so every day I say to myself, well, I'll just drink half a bottle of wine (…). I can't really put different things, distractions in to give myself a different routine particularly, or not as easily as I previously could (…). I think there's a bit of apathy [that] sets in when life is closing down a bit and you think, well, what else is there to enjoy? I can't go [abroad, where I have a second home]. I can't go out and socialise and meet people. So my comfort is a bit of wine in the evening. (Harriet, 61, rural area)

Harriet, who lives alone, was living a highly mobile lifestyle prior to lockdown, dividing her time between her UK home and property abroad. The necessity to stay within the confines of her home alone led to boredom, restlessness, and ultimately an increase in Harriet's drinking. While our other interviewees did not lead similarly mobile lives, boredom was a common complaint, and one of the key emotions which led some people to drinking (more).

Significantly, in most of the cases presented above, it was a combination of factors rather than one single factor that led to a rise in drinking levels. For instance, Helen was having sleep problems but was also feeling trapped in her flat, isolated from her grandchildren, and bored. Ian had lost his job and became homeless, these difficulties exacerbated by the pandemic. Mary had retired shortly before the pandemic and this coincided with a deterioration in her sister's health plus financial difficulties. John had lost his wife and this difficulty was magnified by social distancing restrictions and not being able to have family and friends around at this time. Harriet was forced to give up her usual group activities and travelling which served as her distractions from drinking, leading to feelings of loneliness, isolation, boredom and low mood. Therefore, increases in drinking were usually spurred by a combination of factors, the effects of which had been magnified by lockdown conditions, rather than one single cause.

Reasons behind decreased drinking

Overall, almost half (14/30) of our interviewees had decreased their drinking over lockdown. While in some cases cutting down on drinking was a conscious decision and a goal people were working towards, in others it was an unexpected 'side-effect' of lockdown restrictions.

Out of the 14 persons who had decreased their drinking levels at some point during lockdown, eight only did so after an initial sharp increase in alcohol consumption. A few of our interviewees decided to limit their drinking as a result of experiencing alcohol-related medical interventions or health issues exacerbated by drinking. Medical professionals played a key role in the process as they referred such patients to alcohol treatment services. For example, Helen, mentioned in the previous section, had an accident because of her drinking episode. She was taken to hospital which led to her subsequent referral to an alcohol service. For her and

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some other participants who had refrained from drinking for many years, the sudden increase in drinking during lockdown was a 'blip' which resulted in hospitalisation. However, following this event, they returned to abstinence.

For some of our interviewees the initial increase in drinking during the pandemic was spurred by upheaval or adverse circumstances, such as homelessness or family issues. Once their situation had settled or improved slightly, they had managed to cut down on drinking with the support of an alcohol service. This was the case for one of our participants who had fallen victim of family conflict and elder abuse. Jean, an 80-year-old living in a house in a rural area, agreed to her daughter and her partner moving in with her a few months before lockdown. They had offered to take care of her in return. However, instead of the promised support, Jean subsequently experienced elder abuse. She started drinking spirits to cope with the situation:

> I finished up sitting in my bedroom on the bed and they just took over everything else, they [my daughter and her partner] just took it over. They made friends with all my friends and neighbours and then slowly, and I know this because they've told me, she just poisoned their minds against me. So, it was an absolute nightmare, so I then, perhaps not consciously, but I started drinking whisky. (Jean, 80, rural area)

When the situation further escalated, Jean felt threatened and called the police. Social and medical services became involved, and her daughter and her partner had subsequently moved out. It was only then that Jean managed to reduce her drinking, with the support of an alcohol service.

Only one interviewee felt the pandemic had not impacted on his drinking levels and decision to reduce these in any way:

> It's [my drinking] changed but not because of lockdown – through choices and through an awareness that I should cut down and I have cut down. But that's not as a result of lockdown, that's as a result of me deciding I need to reduce drinking of alcohol. (…) I choose to reduce my intake, I choose to drink less, I keep a drinks diary so I can keep an eye on how much and what it is. (Raymond, 65, rural area)

Paradoxically, reducing drinking levels was sometimes a somewhat unexpected side-effect of the pandemic. For instance, David had been engaged with an alcohol service for a number of years but continued drinking at harmful levels before the pandemic – a bottle of vodka a day. After lockdown happened, he had started reducing his drinking to 'healthier levels', for reasons he found difficult to explain. He was continuing to receive regular alcohol support and found confiding in his alcohol worker helpful. Simultaneously, his everyday circumstances had also changed in result of lockdown. He spent most of his time in a recently purchased caravan with his wife, developed a daily routine, and started eating regularly. David felt like he was 'having a break' and found his cravings for alcohol had – quite unexpectedly – simply diminished:

> I think it's [lockdown] helped me more than anything. I don't know why, but (…) I'm not drinking as much (…). I'm having the odd can, and I'm ruling that rather

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> than that ruling me. That's one thing I have noticed. Well, to be truthful, between me and you, I've enjoyed it [lockdown]. [Before lockdown] I was hooked [on alcohol], I was literally, that's all I thought about from getting up, you know, when the shops opened. It just, I don't know, my head's in a better place, that's what I say. (David, 67, urban area)

David found that by changing place of usual residence he gained a new, more positive outlook on life, which had spurred him to spontaneously cut down on drinking. Robert, in turn, had also changed place of usual residence during lockdown but under very different circumstances – he was taken into a care home due to alcohol-related health issues. As a result of the restrictions, Robert stayed there for an extended period, and found this had helped him greatly in controlling his drinking:

> It [drinking] can be a problem at times, you know (…). That's why I came in here [the care home] to see if they could stop it, you know (…). I was kind of bad when I came in here at first, you know, depressed and what not, you know. But then I came to and I got on all right with the staff and everything. I'm feeling good now right enough. Get your meals and everything, anything at all (…). What I do in here, it doesn't bother me at all, alcohol or that. No, not a bit. It doesn't bother me at all, I'm hoping when I get out I'll be all right, I'll be okay, I hope so, I hope so anyway, aye. (Robert, 65, rural area)

Similarly to Robert, a few other interviewees were kept in hospitals or taken into care homes for extended periods with the aim of providing adequate care for their health conditions and helping them abstain from alcohol. They had also been referred to an alcohol service by medical staff. This intervention was perceived to be helpful and resulted in reduced alcohol use or abstinence.

In some cases, a reduction in drinking levels resulted from difficulties with shopping. For instance, Joseph, a heavy drinker with mobility issues, found himself drinking less under lockdown due to 'the river running dry' rather than taking a conscious decision to cut down:

> My friend will maybe go in [to do the shopping for me] on Monday and maybe not here again 'til Wednesday or Thursday or something, you know. So I just… maybe two or three drams a day, so I just… I eek it out, you know what I mean, so… I suppose that's a good thing as well, you know. (…) It's more like drinking in moderation. (Joseph, 62, rural area)'

Summarising, while in some cases the pandemic facilitated the decision to reduce drinking, in others this was an unexpected side effect of change in living environment or practical difficulties in sourcing alcohol.

Factors supporting remaining abstinent or drinking at low levels

Notably, 12 (out of 30) people in our sample were in alcohol treatment and abstinent prior to the pandemic and remained sober throughout the first UK lockdown (up till the point of interview in July–September 2020). These people had been involved with alcohol services for varying periods of time pre-pandemic, from a

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few weeks to several years. Of the 12, nine persons continued using alcohol services remotely (mainly by phone) over lockdown.

Those who had stopped drinking shortly before lockdown found the restrictions supported their goal of abstinence. With pubs closed and socialising prohibited, participants were unable to engage in social drinking, be it meeting with their 'drink buddies' in pubs or at home or drinking during family outings. In some cases, lockdown brought about a sense of peace entailed by having time away from a stressful job or conflicts outside the home. For instance, Michael, who had gone through residential detoxification right before lockdown, said:

> I know it's the poorest time in years, but I've just enjoyed time off (…). The lockdown has been a saviour to the family and enjoyment for me. So I would say there's a peace and serenity about it. I've just learned to slow down, be calm (…). Lockdown to me was a perfect scenario because the pubs weren't open, you know, my family weren't going out and the get togethers would have been in the house or the back garden. I was having to control that situation, so in a way I'm sad to see the lockdown going (…). (Michael, 57, rural area)

Indeed, lockdown was seen as 'a godsend' by people who had only started alcohol treatment during this period, and largely helped them refrain from drinking. As indicated by Michael, some participants were troubled by the prospect of restrictions being eased and losing a sense of control over their situation once 'things go back to normal.'

For people maintaining abstinence, the ability to tackle boredom within the confines of one's home or property proved crucial to maintaining well-being and coping with drinking urges, especially for those living alone. Self-care, finding effective ways of looking after one's mental health and finding enjoyable tasks to do was what helped older people in alcohol treatment maintain abstinence or low levels of drinking. Having a garden or easy access to a green space was seen as a definite advantage under the circumstances:

> I love planting wee flowers, I love being out in the garden, I love feeding the wee birds, I love watching their antics when I'm down sunbathing, the mummy bird feeding the baby birds, and I've just enjoyed, I bring the radio if it's a good enough day, I take my reclining chair down, I take my bottle of water down, I take my fruit down, and I'll put food out for the wee birds and watch them, and I always have my radio down with me, I do listen to my music. (Elizabeth, 67, urban area)

However, people maintaining abstinence and low levels of drinking throughout the pandemic were generally also able to find enjoyable indoor pastimes:

> I'm one of the lucky ones. [I've always enjoyed] sewing. I was making masks for staff in here. That's what kept me going. [And] I started knitting (…). [T]he other day I had a coffee table that was getting on my nerves, so I decided to sand the coffee table down and I painted it white (…). You know, keeping the old brain going, you know, them things. (Margaret, 75, rural area)

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Margaret cited above summarised her coping strategies throughout lockdown as: to talk to people on the phone, *'keep yourself busy, and eat well and sleep.'* These strategies helped her manage her mental health and deal emotionally with lockdown, maintain a positive mindset, and refrain from drinking.

Participants used a number of strategies to self-regulate alcohol use and maintain abstinence or low levels of drinking during the pandemic. Some of these were standard strategies which could be used under any circumstances, such as keeping a drinks diary or scheduling alcohol-free days. Others were developed specifically to manage lockdown conditions. For instance, being able to find suitable new distractions was of crucial importance:

> I'm very much on my iPad at the moment. I play Scrabble. If I'm thinking about having a drink, I'll go and I'll fill myself up with water, and I'll put my mind somewhere else. (Frances, 79, rural area)

> I drink something else, water, coffee, whatever, something like that and I keep my hands occupied, I crochet and when I'm sitting watching television of an evening, instead of having my hands full of a drink then I'm just glugging, I sit there with my hands full of crochet and the drink I reach for is a sparkling water. That works quite well for me. (Mary, 70, rural area)

Moreover, the role of having reliable support structures and receiving adequate emotional support cannot be underestimated. The majority of our interviewees struggled with the enforced isolation and not being able to visit or see family or friends. Significantly, for most people in longer-term alcohol treatment, face-to-face support was no longer available. Under the circumstances, support provided by alcohol services remotely was crucial for maintaining abstinence:

> The support, it was amazing. It was really, really, really good. Because they kept in touch, and it's been amazing. Without… See, if I didn't have the support group during the lockdown, I wouldn't have been able to cope, I wouldn't have. I don't think I would have been able to cope, I think I might have been back on the drink, to be honest with you. But with having the support, and having somebody that listens to me, you know, it's amazing, you know. (Henry, 62, urban area)

In some cases, people undergoing alcohol treatment were able to connect with others in a similar situation, which they also found extremely helpful and motivating:

> There's another man living beside me and he's off the drink the same length of time and I was talking to him, you see, then to know that he's off and I'm off. (Patrick, 68, rural area)

Lockdown conditions have drawn out the particular importance of being able to put oneself in a positive mindset. Being able to combat negative thinking, especially if confined to one's one home, proved crucial for maintaining abstinence:

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> I've learned to meditate. Not meditate, I would still have to learn more, but I've learned to try and turn negatives into positives, because negatives just don't work. Even if you go to sleep with negatives in your head there, you'll be negative all night, in your dreams. But if you can create your negatives into positives and take care to slow down and meditate that slowness, that gives you a whole different night's rest, and you wake up totally different the next morning. (Michael, 57, rural area)

Notably, while people who had stopped drinking shortly before or during the pandemic found the restrictions supported alcohol treatment, some in longer-term treatment were struggling. For some long-term service users not being able to see their recovery worker in person or attend peer support meetings was highly challenging. Despite the strong remote support received from services, a number of people in longer-term treatment expressed worry around their ability to remain abstinent if the restrictions were to continue over an extended period of time.

Discussion

This study aimed to explore the reasons behind changes to older adults' drinking patterns during the COVID-19 pandemic. Specifically, we focused on a distinct population of older adults aged 55+ who were at different stages of alcohol treatment. Our study demonstrates that increased drinking was caused by a combination of factors, including loneliness and isolation, boredom, lack of access to usual pastimes, family conflict, caring responsibilities, bereavement, work issues, financial issues, and lack of access to adequate healthcare and mental health support. Conversely, for some older adults the restrictions supported the goal of treatment and reduced alcohol use. For participants new to alcohol treatment, the closure of social drinking spaces facilitated abstinence. Vulnerable people in longer-term treatment placed in hospitals or care homes during lockdown also found this helpful in managing their drinking. Older adults who developed adequate coping strategies and self-care practices coped best with the pandemic and managed to maintain abstinence or drinking at low levels.

Research indicates that among the general population of older people, anxiety, lack of work, stress and psychological distress resulted in increased use of alcohol during the pandemic (Centre for Ageing Better, 2020; Rodriguez *et al.*, 2020), whereas the closure of pubs and other social spaces related to drinking resulted in decreased drinking (Centre for Ageing Better, 2020). Our study of older people who used alcohol services during COVID-19 provides more nuanced insights into the changes to drinking patterns. Viewing these through the lens of the Socio-Ecological Framework (Golden and Earp, 2012) highlights the range of factors that were at play during the pandemic, primarily those relating to personal, intrapersonal, community and institutional influences. For example, increased drinking was related to personal issues such as boredom, community issues such as greater isolation (*e.g.* grieving alone), and institutional problems including the lack of access to primary care and social support. Covid restrictions also resulted in more positive impacts as reported by the majority in our study who either reduced their drinking or remained abstinent. Some changed their living (Community) circumstances (*e.g.* by moving to a holiday caravan) to enhance

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their way of life, or made use of institutional opportunities (*e.g.* moving to a care home) to receive better support. Other institutional benefits included hospital stay and continued support from alcohol services. Positive coping mechanisms were viewed as a means of dealing with lockdown and reducing or abstaining from alcohol. These included taking up new indoor and outdoor pursuits (Community), staying in touch with family and friends using digital media (Intrapersonal), and drinking non-alcohol drinks or maintaining a drinking diary to help limit their intake of alcohol (Personal).

This study is unique. To the best of our knowledge, this is the only research examining the impact of the COVID-19 pandemic on changes in drinking patterns among older adults receiving formal support for alcohol-related problems. We carried out a robust analysis of qualitative data both thematically and comparatively. Compared with existing research, this allowed for a highly nuanced analysis of the proximal and distal influences of alcohol use among older adults during the pandemic which map onto the Socio-Ecological Framework.

However, our study had a number of limitations. Older adults were invited to take part in the study by service staff and this may have resulted in an element of selection bias. In addition, recruitment was challenging as many services did not have a large number of adults aged 55+ in treatment; this meant that the approach to sampling was more opportunistic than initially planned. Moreover, this was a cross-sectional qualitative study focusing on the possible impacts of the pandemic on interviewees' drinking. It provided a snapshot at a certain point in time based on our interviewees' reports and perceptions. The data collected was relevant to our key research questions for the study, which focused on experiences of alcohol service provision during COVID-19. We aimed to carry out purposeful sampling by age/gender/rurality and this was the demographic data collected for the purposes of analysis. We did not directly ask interviewees about drinking histories or treatment trajectories, though such information was spontaneously shared during interviews. A prospective cohort study would provide the opportunity to compare experiences including alcohol consumption and related harms pre- and during COVID-19. Quantitative measures such as AUDIT-C might assist in these comparisons. Adding an out-of-treatment comparison group of older drinkers would also provide greater insight into the impact of the COVID-19 pandemic on possible alcohol-related outcomes.

This study has implications for future interventions. We think resilience-based interventions might help. These fit reasonably well with key components of the Socio-Ecological Theory. At a personal level, resilience is based on the ability to maintain healthy levels of function over time despite adversity, or to return to normal function after adversity (Johnston *et al.*, 2015; MacLeod *et al.*, 2016). Significantly, resilience does not exist in a vacuum (Sippel *et al.*, 2015) but is embedded in close relationships with other people (Southwick *et al.*, 2014) and in the lived environment (Almedom, 2015). Building resilience thus encompasses three domains (Janssen *et al.*, 2011): individual (which includes efforts to exert control and the capacity to analyse and understand one's own situation), social (which is embedded in relationships with others), and environmental (the broader environment one lives in, material resources, and available forms of formal support, such as accessibility of care).

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We recommend resilience-based alcohol interventions should be made available for older adults. These should aim to develop and strengthen resilience within three domains: individual, social and structural. These might comprise developing individual-level resilience and coping mechanisms that help older people to control their alcohol use. For example, in the context of a likely pandemic – proactively teaching coping strategies such as self-care and a positive mindset. At a social level, it may entail connecting people with existing social networks or helping them to connect with new networks. This is especially true for people in alcohol treatment who have not moved out of social 'drinking' networks. Similarly, for participants who wish to remain abstinent, the lack of an external support structure facilitating opportunities for engagement and sociability may hinder that aspiration. An example of an intervention that focusses on personal and social aspects of resilience is Drink Wise, Age Well. However, developing environmental resilience is likely to fall outside the scope of existing alcohol services. Change is largely dependent on national government policy to bring about better living and working conditions that are conducive to health. Introducing policies that improve housing, employment opportunities or changes to the welfare system are notable examples.

There are also a number of implications for research. Our study was carried out on a specific group of older adults, namely those using alcohol treatment services during the pandemic. Comparative research on older adults with alcohol issues who are not in alcohol treatment may shed some light on the extent and scope of unrecognised needs of this group. Understanding how and why patterns of alcohol use have shifted among these groups too may help in wider planning for alcohol treatment services during pandemics, disasters and national emergencies which are likely to create similar conditions. Furthermore, our results point to the key importance of developing resilience-based interventions for older adults with alcohol issues. A feasibility study that evaluates the implementation, acceptability and practicality of such interventions should be prioritised.

Finally, this study provides some insights into the support needs of older alcohol service users as restrictions ease. The older people who had started alcohol treatment shortly before lockdown felt the restrictions supported this goal: opportunities for social drinking had been largely removed. However, they worried about moving out of lockdown and needing to control their drinking urges under 'real life' conditions. This indicates this group of users might need increased support as restrictions ease. Furthermore, many service users in longer-term treatment struggled with the lack of face-to-face support, particularly from peer groups, over lockdown. Providing such face-to-face support as soon as possible appears essential for this group. Finally, alcohol services need to consider that the pandemic might last longer than envisaged and restrictions might be re-introduced at any point. Therefore, preparing both alcohol services and older service users for such an eventuality – with particular focus on digital literacy and inclusion – seems essential.

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